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# children

Coordinating Professional Efforts

Volunteers With School Groups

Family-Centered Child Placement

A Social Worker in Maternity Care

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# children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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The bond of love bridges a three generation gap between two Americans—a Dakota Indian baby and her great grandmother. The baby's future, and perhaps the future of this Nation and the world, may depend, in great part, on whether children can be assured the kind of early childhood conducive to healthy physical and mental development. (See pages 210 to 213.)

# children

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The Secretary of Health, Education, and Welfare was the chief U.S. delegate to the first International Conference of Ministers Responsible for Social Welfare, convened by the United Nations in New York, September 3–12, 1968. As the condensation of his address presented here indicates, he stressed . . .

In a world with many differences, human problems and potentials are common threads. Every country is involved in efforts to meet the needs of its citizens. Each nation is challenged to develop its human resources to the fullest extent possible. Certainly the tasks that confront the world in taking up this challenge are not identical for all nations. They do, however, have important similarities.

For this reason we in the United States were greatly pleased when U Thant, the distinguished Secretary General of the United Nations, announced that an International Conference of Ministers Responsible for Social Welfare would be convened. The convening of this conference marks a new stage in international development. It highlights the priority which member states assign to national programs for meeting human needs. The social service sector, long a junior partner in the international family, is finally achieving the stature and visibility consistent with its place in national governments.

Our countries are confronted with the task of resolving and preventing complex social and economic problems. We are looking for ways to encourage healthy social and economic growth; to provide constructive employment opportunities for those who can work and social services for those who suffer from the major hazards of life. We are searching for

# the DEVELOPMENTAL APPROACH to ▶ SOCIAL CHALLENGES

WILBUR J. COHEN

new ways of enriching the experience of children, for more effective methods of dealing with the social needs of families in crowded urban areas, for better methods of enlisting wider participation of our citizens in planning social services. We are looking for improved ways to meet the challenges of persistent poverty, of discrimination, of urban and rural neglect.

We are, in other words, attempting to create societies which maximize the independence, self-reliance, and self-respect of all citizens—

- societies which are truly open, in which every individual has the opportunity to develop to his fullest capacity;
- societies in which every man and woman has the opportunity to earn an adequate living and to enjoy the good life;
- societies in which conditions that stunt human development and prevent personal fulfillment no longer exist;
- societies in which every person has the freedom to choose among many options—in work and leisure, in homes and in friends—indeed, in the purpose of life;
- societies in which individual dignity is enhanced and the human spirit liberated.

Despite limited resources, the past achievements of the United Nations in advancing social services in many parts of the world are impressive. The rapid growth in social programs, especially in newly developing areas, can be attributed in part at least to the excellent cooperation between national governments and the United Nations headquarters and regional personnel. Results of this cooperation can be seen, for example, in the existence of well-established national social service structures, in more than 100 schools of social work throughout the world that have been strengthened with U.N. assistance to prepare staff for expanding social service programs, and in demonstration projects testing new combinations of services and imaginative uses of nonprofessional workers. Certainly one worldwide social need is for additional social service personnel at all levels of training and competence.

## Developmental services

Those of us who share the responsibility for improving the social services of our countries are faced with many challenges. One of the broadest and most important of these is the challenge of planning and implementing social service programs in the context of national development.

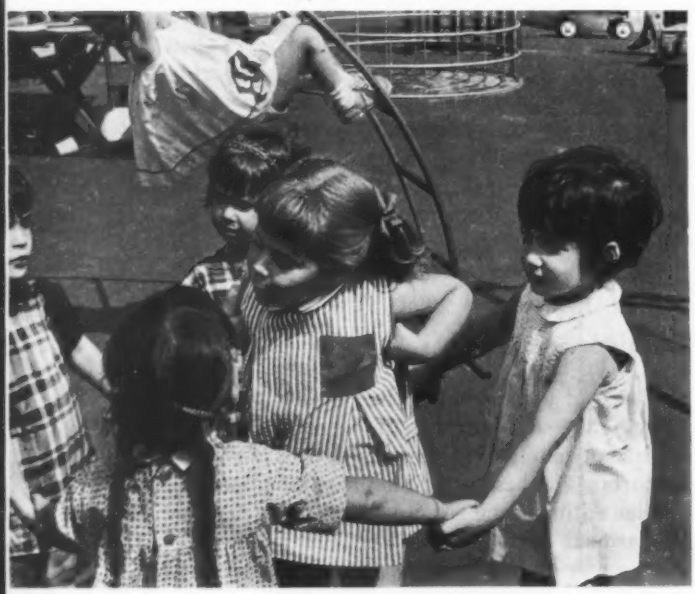
One way of meeting this challenge is by expand-

ing the developmental approach to service. In this approach, the social welfare field does not wait for its work to be created by default, but rather attempts to direct part of the social resources toward efforts to enhance the content of living; to strengthen individual and family development: to provide social opportunity as well as social security.

Too often in the past social programs have focused on remedial action after economic and other changes have created social and economic problems. With the speed of modern development, social programs must increasingly stress preventive services and constructive actions. Today, as never before, we must both envision how society is going to be in the future and take steps to assure individual and family well-being in changing conditions. To do this we need a clear understanding of present social conditions and of how these conditions change. We need ways of measuring the magnitude of social problems and methods of evaluating the effectiveness of different attempts to deal with these problems.

Unfortunately, most existing social data in the United States are byproducts of the need for accounting and administrative routine. They tell us more about the operation of organizations than they do about the condition of society or the effectiveness of programs. We need better social data and strengthened social research resources—both nationally and under United Nations auspices—to do the most good with the social service resources that are available or anticipated.

A group of children in a play period in a nursery school. The importance of preschool education to child development is receiving increasing attention throughout the world.



## Early childhood development

One area in which we in the United States are using a developmental approach is early childhood. We are attempting to provide positive experiences and environments for children that will prepare them for healthy, productive, and meaningful lives as adults.

As in many countries, the thrust of our current efforts and of our proposals is the creation of a comprehensive set of services available to all children. These health, education, and social services are to be family centered and interrelated. They are not designed to be remedial programs responding to problems that already exist, although important remedial services, such as income maintenance, are basic elements to any comprehensive plan. Instead, they are intended to anticipate and remove conditions that have a high probability of presenting future problems. Their ultimate goal is to prepare a child to take full advantage of his talents and to develop all his potentials.

The development of healthy children begins with the provision of adequate prenatal and postnatal care for all mothers and infants. Important emphasis should be given to providing high quality medical care for all children in their early years to prevent disease, cure illness, and correct handicaps. Often conditions, such as visual defects, that could lead to permanent damage and disability in later life can be either prevented or corrected in children at an early age.

Some of the most promising new ideas in the field of child development relate to early learning abilities. There is a growing body of knowledge that very young children can be stimulated to learn far more than has been expected in the past. The experience of day care centers in many countries, and of Project Headstart in the United States, has demonstrated what can be done for children in the immediate preschool years. We hope to see such programs considerably extended.

The opportunities are unlimited. There is room to go far beyond the traditional school setting to have an impact on learning and motivation. We can take advantage of the knowledge and skills of many professional groups and of the active participation of

parents, neighbors, and other children. A concerted effort must be made to involve parents in these programs and to give them a significant voice in the decisions affecting their children's health, education, and welfare. This would strengthen the home and raise the quality of family life.

## Strengthening family life

In the final analysis, a central purpose of our efforts in child development, as in other social service efforts, is to enhance the quality of family life. The family has been and continues to be the basic social unit in society, and social services seek to strengthen it and preserve its integrity. The many excellent cooperative projects developed by the United Nations and the United Nations Children's Fund (UNICEF) have had as their primary justification that they serve as a first step in developing organized national systems of social service to preserve and strengthen family life and foster opportunities for the healthy growth of the personalities, abilities, and social habits of children.

In this regard, we would like to see mothers become as well versed in the skills of preschool education as they are in the skills of homemaking. The home would become an increasingly productive educational environment. If we are to meet the challenges of child development, vital learning experiences should be brought to children wherever they are and in all their activities. We must bring encouragement and motivation to each child by helping him experience a sense of achievement, of being able to deal with the environment, and, thus, develop a willingness to grapple with problems and seeks solutions.

To do this, we must be concerned with the whole child and all the factors that relate to his potential. Healthy development depends on the parents and other members of the family, the neighborhood, the surroundings, the school, and the attitudes of persons who influence the child.

Social services and social work skills have made significant contributions to these efforts in behalf of the health and education of children, and they will be called upon to make more. In the United States, persons and agencies working in the fields of health, education, and social service often benefit from close cooperation with each other. For example, many day care programs have important education, health, and social service components. Social work skills are used in working with the children's parents to involve them in the program and to mobilize their support for its efforts. Similarly, social workers are being used in health programs to assist mothers in the use of health services, to assure that the parents of prospective patients are aware of the services that exist and are able to use them. This type of cooperation is vitally important.

The potential for successful cooperation among persons working in the health, education, and social service fields is, perhaps, greatest in the area of family planning. One of the most important determinants of healthy child development is a child's feeling of being wanted by his parents. Family planning services available to all parents on a voluntary basis can contribute significantly to the well-being of families, and so of children, by preventing unwanted pregnancies.

## International cooperation

Modern knowledge of early childhood development raises questions about what blend of developmental, preventive, and remedial programs is appropriate in any one particular national context. This suggests the value of exchanging experiences and knowledge between countries and the importance of extending and strengthening technical cooperation and research efforts. It points to the need for more extensive social service planning in the related areas of health and education as well as in all areas of national development. Finally, and implicitly, it points to the need for trained manpower to implement social service programs effectively at all levels.

Programs in early childhood development can make significant contributions to the economic and social vitality of a nation. Societies need healthy economic growth to offer their citizens opportunities for constructive employment and social service programs to protect and strengthen those who suffer from the major hazards of life.

There can be no question that the nations of the world are confronted with complex and challenging social problems. The United Nations has an important and increasing role to play in their resolution. Through the Conference of Ministers Responsible for Social Welfare it can make a lasting contribution to the well-being of individuals wherever they live.

# coordinating professional efforts for children with school problems

SAUL L. BROWN, M.D.

Within the broad range of mental health services for children, four disciplines frequently intersect: special education, clinical psychology, clinical social work, and psychiatry. Representatives of these professions constitute the major portion of practitioners in the mental health field. Mutual respect and acceptance among them is steadily increasing, but it does not always come about easily. It requires a consistent effort and a place where such an effort can occur.

One place the four mental health professions may come together is the school, public or private. A place where they *must* come together, I believe, is the specialized school or the specialized classroom for children with major educational or behavioral problems, or both.

Another place for such coordinated professional effort is the modern psychiatric clinical center whose services include day care and inpatient programs for disturbed children. In such centers, special educators (increasingly referred to as "educational therapists") are core participants along with psychologists, nurses, psychiatrists, and clinical social workers. Also in these settings various specialists in art, drama, music, physical education, dance, and other activities provide a mixture of educative-therapeutic experiences for patients.

Professional persons working both within and in relation to these "community mental health centers" need to evolve efficient and yet flexible methods of communication. Children coming to such centers may spend only part of each day there while still enrolled in school, or they may spend a full day in the center. In either case, the clinical work with them needs to be effectively integrated with their school and other educational experiences.

In many psychiatric hospitals and residential treatment centers where therapeutic milieux have been developed, the clinical experience provides a model for interprofessional communication. Many of the following observations are drawn from such clinical experience.

## The common task

It may be useful to differentiate between professional persons for whom education is the primary mental health focus and those for whom therapy is the major focus, even though their activities overlap. What special educators and the therapists face in common, regardless of the setting, is a child with a history of failure who has developed subtle means for avoiding and covering up a badly damaged self-esteem, who is often angry, easily panicked, easily

frustrated, and frequently depressed. Usually such a child has parents who, even if they have in many ways provoked the child's difficulties, are also victims of those difficulties. They usually have developed their own special brand of guilt feelings, defensiveness, hostility, impatience, or other reactions to their frustrations. These traits operate in vicious circles and not in a direct line of cause and effect.

The first task for the mental health professional, whether a specialized educator or psychotherapist, is to become meaningfully involved in the problems of the parents and child without becoming locked in a *new* set of vicious circles with the child and his parents.

How is this kind of objective involvement to be achieved? The best way I know is through a repetitive working out together of a common professional purpose by all who are concerned: the child, the mental health professionals of various types working with him, the school administrator, the parents, the welfare worker if the family is receiving some form of help from the welfare department, and the pediatrician, probation worker, or public health nurse if such persons have also been concerned with the child. How is this coming together to be achieved? Who is to engineer it? Where should the initiative come from? What sort of expertise is needed?

## Items for integration

Too often professional persons drift into comfortable channels of function that, little by little as the years go by and their youthful zeal diminishes, become rigid and are then rationalized as necessary. There is no better antidote for this tendency than open-ended, problem-centered, small group discussions, encouraged from the administrative top but pushed for from the working staff below. Organizing dynamic interprofessional group discussion and planning is certainly not easy. But unless it is done, an enormous amount of professional energy may be spent in separate settings—classrooms, play therapy rooms, psychological testing offices, or whatever—with little accomplished.

Following are some basic items around which I believe educative intervention and therapeutic intervention need to be integrated:

1. ***Picking up the problem where it is.*** In some instances, the child and his parents are well oriented to their educational problems and are able to enter into a reparative program of education and, perhaps, psychotherapy. In most instances, however, parents and child need to be "worked with"; that is, their feelings of frustration, shame, anger, mutual accusation, and hostile defensiveness need to be met before they can settle down to the educational task or the therapeutic undertaking considered necessary for them.

Those of us who work professionally with emotionally disturbed children constantly talk about "meeting the child and his parents where they are." To do so requires the development of rapport with the child and the parents so that they will *feel safe with us.* The route to creating a feeling of safety in some children or their parents is to be tentative, easy going, and low-pressure; in others, to be methodical and even compulsive in early dealings with them; in a few, to be dogmatic.

Thus the professional approach has to be flexible and derived from diagnostic appraisal. It should not be a rote procedure applied according to formula, nor, on the other hand, should it be merely subjective and determined only by the here and now. It must be based on some understanding of why the child and parents behave as they do. This leads to the next item.

2. ***Diagnosis and the needs now.*** The diagnosis itself should not be rigidly fixed. If it is really to fulfill a purpose, it needs to be a framework within which pertinent and usable modes of action can keep evolving on behalf of a particular child *now*, at a specific time, and from one phase to the next. Because, the "now" is always shifting, group planning and discussion are clearly required for a meaningful diagnosis. Through group discussions many variables can be recognized and weighed. If the problem is to be met where it is, the diagnostic approach must include not only the traditional psychological and psychometric data, but also a sensitive appraisal of how the emotional life of the total family organizes around the particular child under study. Moreover, a simultaneous estimate needs to be made of the emotional level on which the authorities at the child's school are operating *now* in relation to the child and his family.

All of these factors need to be considered by the professional person who is working in a mental health clinic or a private office when making a diagnostic evaluation of a child with problems in learning and school adjustment. Similarly, the special educator or school psychologist is more likely to help the child succeed if his plan for the child is based on consideration of all of these factors, not simply on a psychometric-psychodiagnostic study.

One way to make this possible in a special educa-

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tion school is through at least one preliminary meeting of the child, his parents, and those mental health professionals who are or will be involved with the family. In such a session, everyone together focuses attention on what the educational problem is, how the family views it, and how the therapists—if any are involved—see it. This reduces the overload of expectation that may be placed on the educators, it helps set goals as well as define limits, and it helps the child see why he is in the situation at all. Clearly, the leadership of such diagnostic-planning sessions must be carried by a sensitive, professionally trained person who is responsive to the needs of each of the participants. Although this is time consuming in the beginning, it prevents a greater loss of time from occurring later because of misunderstandings and poorly defined objectives.

3. ***Resistance to change.*** The common professional objective of all of us who work with emotionally disturbed children is to facilitate constructive change. To achieve this, we need to identify and sort out the more significant and potent areas of resistance to change. We cannot always do something about it, but designating the nature and locus of resistance shows us what we are up against. This kind of designation is really a process. It cannot be done once and regarded as a finished product. As new events occur and new observations are shared by the various professional persons involved, we can arrive at a relatively consistent series of actions to be taken. Again, when this process is focused on a child with problems of learning or school adjustment, it needs to be a group process.

If, for example, the child's parents manifest an attitude of protective defensiveness over his learning problem, the professional persons concerned need to define this as a first resistance to change. Doing so is a part of the diagnosis. It means that a unified approach to this resistance must be worked out by all who are involved in the case before efforts are made to define a particular educational or therapeutic program for the child.

Or if the school personnel, including teachers, principals, counselors, janitors, office clerks, school nurses, and others have become stirred up by the child's behavior to feelings of rage toward the child or his family, this state of affairs has to be recognized as a resistance to change that needs to be dealt with.

Similarly, if a professional person working in a psychiatric center has met with frustration in his effort to involve the parents or child in psychotherapy, this fact must be a part of the diagnostic formulation shared with the school authorities.

**In one case, for example, the parents were convinced that their distractible 10-year-old son had minimal brain damage. One pediatrician thought he might have such brain damage, but another doubted it and referred the parents to the psychiatric center. It became clear that the entire family needed psychotherapy and that the boy needed a special educational experience. The psychotherapist felt unable to get through to the parents, however, and made this known in open group discussion to representatives from the school with the parents and boy present. He was careful not to be critical. He simply reported his impressions.**

**This frankness on the part of the psychotherapist allowed the educators to move into the situation, using the therapist's comments as a baseline for dealing with the family's resistance. Psychotherapy was postponed, with everyone's agreement. But the parents, the child, and the school authorities all were in on the plan and each shared responsibility for it. At a later date, when the school administrator confronted the family with the fact that progress was not occurring in spite of the educational efforts, the parents seemed more open to using psychotherapy. They began this jointly at the clinic after attending a clarification conference with their child, the school administrator, one of the teachers, and the psychotherapist.**

The other side of the coin from designation of areas of resistance to change is designation of positive factors for change. Certain persons in the school—perhaps a maintenance man, a more senior student, or a clerk—may have a closer relationship with a specific child than do his teachers. If so, this fact should be made an active element in the diagnostic formulation. The person should be asked to participate in the periodic joint planning sessions. This process is often carried out in residential treatment centers and progressively administered psychiatric wards.

**In one such instance at a private school for emotionally disturbed children, the clerk-receptionist had developed a warm relationship with a very timid 11-year-old girl. When the staff became aware of the relationship, the clerk was included in**

its conferences relating to this particular child. The clerk's role as a therapeutic agent became defined, thus averting a too personal involvement but also amplifying her usefulness to the total professional effort. At one point, the child's parents seemed about to separate and she developed a school phobia. The receptionist was the staff member most able to reach her in the acute phase of her phobia; through well-timed use of her relationship with the child, a severe school problem was avoided.

Much more might be said about meeting resistance to change and facilitating change. For example, it is important to understand what authority means to a particular child through observations of how authority is used in his family; or what language means to him through observations of how language is used or manipulated in his family; or what curiosity means to him, again, as it is handled in his family. All of these factors enter into diagnosis as an instrument for action in the educational therapeutic process. But no diagnostic statement about any of these factors is useful unless it is discussed and clarified in group meetings by everyone who is professionally involved with the child.

For example, when a child compulsively fights against authority, this becomes a resistance to change in the school environment. When the professional persons are able to define this area of resistance, through group discussion, it shifts the problem from a one-to-one battle between the child and each adult in the school to a coordinated group concern. The new perspective leads everyone who deals with the child to meet his provocations in a uniform way. If these persons also understand the origin of his problem through having met together with the parents, or the whole family, an even better professional group approach to his behavior may evolve.

4. ***Shifting loci of resistance.*** We are coming to realize that the existence of a major learning disorder or school adjustment problem in one child often serves a psychological function for various members of his family; that is, it enters into and defines, in some degree, the intrafamilial dynamics. Regardless of its ultimate cause—intrapsychic, organic, or whatever—the very existence of a learning problem in a child becomes a dynamic force in the family life. Much of the family psychology and emotionality concentrates on it. If, therefore, certain educational measures succeed with the child, they may paradoxically affect the family in a negative way. A new area of resistance to constructive change, even a dramatic crisis, may suddenly emerge. Clinical observations have been made of families in which deep depressions or psychotic reactions have occurred in one parent following a child's definite improvement. Sometimes a psychosomatic regression develops in one member of the family or in the child himself as the learning disorder disappears. Occasionally a severe marital crisis erupts.

Often as a child begins to improve educationally, the emotional threat to other members of the family leads them to act out their hostile feelings against the educational institution or against the child's therapist, if there is one. Sometimes, too, a child becomes frightened of his own new competence and, out of his anxiety, regresses in some other area of functioning. This stirs up new problems, either in school or at home, with members of the family, the therapist, the teacher, or schoolmates.

It is exactly because resistance to change may emerge in new ways as change itself occurs that constant group reappraisal needs to be made in group discussions by the professional persons involved. Such efforts at group reappraisal, if they are to be valuable, cannot be haphazard.

**A 9-year-old boy in a specialized school began to show marked progress in reading. At the same time, his overall concentration span also became noticeably greater and his hyperactivity decreased. His teachers failed to report these developments to the clinical social worker who was seeing the boy and his whole family in weekly therapy sessions. Suddenly, a marked regression occurred in the boy's school work and he became hostile and provocative to his teacher. His father called the school administrator to say that his son did not like the school and he was considering withdrawing him.**

**The administrator recommended a conference with the family therapist. A joint meeting was held of the parents and all the professional persons involved—two teachers (one a tutor), the school administrator, and the family therapist. The child was not included because the family therapist thought that what had precipitated the regression was an emerging marital crisis and that this could be more productively discussed without the child present.**

**In the meeting, the child's school regression showed up clearly as related to his parents' difficulties. The vivid way in which this was brought out allowed the family therapist to show the parents that because of their fear of facing their problems with each other, they had slipped back into using their son as a displacement object. No longer on the defensive, the educators redefined the boy's need for the special school and the parents accepted this. The parents also set themselves to working more actively on their problems with each other. The child's behavior in school quickly improved.**

5. ***Coordinating professional efforts.*** Not only is the coordination of professional efforts in the combined educational-therapeutic process a major job, it may also be a full-time job. It requires a certain aptitude or talent, along with a sophistication about the many

subtle factors operating in the systems responsible for education and for therapy. The kind of group exchange described here needs constant reaffirmation by the persons in charge. Someone needs to be designated to bring it about. It cannot be left to chance.

Whoever exercises this integrative role needs to comprehend, with a minimum of personal or professional bias, the differing objectives of the purely psychotherapeutic undertaking and the purely educational classroom undertaking. He must be able to see them as interlocking rather than as being in a hierarchy of "more" or "less" value. The therapeutic objective is often, although not always, to uncover feelings. The therapist hopes to enlarge the child's capacity for experiencing, recognizing, and acknowledging feelings of various kinds. Often the one-to-one intimacy of play therapy facilitates this. We are learning that the family group meeting often does it even better. However, the process of unveiling feelings and exploring their ambivalent nature may not be realistic for a classroom. In fact, it hinders the work of the class. Moreover, it usually is not a process in which teachers are competent.

There is much room for a natural misunderstanding between teacher and therapist. The teacher, even in a very specialized school or class, may see his primary task as organizing objective information. The therapist, on the other hand, may see his task as pushing toward an awareness of subjective experience. The timing for each of these tasks is a matter for clinical and educational wisdom. It may be that they can both be done at the same time; it may be that one needs more emphasis than the other at a given time. To complicate the situation, the impact of the combined processes upon the family may call for a therapeutic approach to the parents at some point—an encouragement of self-observation and an active discussion of parent-child relationships. But a sudden and ill-timed pressure by the school on the parents to do this can be as harmful as a too early pressure by a therapist on the parents to look into their unconscious conflicts.

The coordinator needs to feel free to draw the therapists out while the professional group is learning the details of the educational scene for each child in treatment. He can then help to bring a balance into the picture.

For a teacher or school administrator to give certain information about the child's therapy to the parents at the wrong time can blow up the whole therapy process. Similarly, a therapist who allows himself to be pulled into a child's or his parents' distorted perceptions about what goes on at the school can blow up the whole educational experience.

The acting out of hostile feelings by child or parents needs to be viewed objectively by all professional persons concerned as part of a sequence of events that inevitably occurs whenever change is introduced. An objective perspective can be maintained if someone has the responsibility for periodically bringing all appropriate persons into a dynamic group review of what is going on. At times the whole family might usefully be a part of the group review. Such a decision must come out of professional collaboration and exchange. The following example illustrates how a "blow up" may occur when efforts are not coordinated.

**A child in a special school for the emotionally disturbed was overly timid and could not invest himself in school work. He was usually depressed. His father had deserted the family 2 years earlier. The boy was seeing a therapist at a clinic weekly. Slowly he developed a discernible affection for his male science teacher. He offered to do errands and extra projects for him. The teacher was a genuinely perceptive young man, but he failed to understand his peculiar importance as a father figure for this boy. It did not occur to him to let the child's therapist know that he would be drafted at the end of the semester, and he waited until the last week of school to announce this to the boy.**

**The child showed no reaction at school to the announcement but he suddenly refused to continue his therapy sessions, and his mother withdrew him from therapy. The boy subsequently regressed in his school work and made no further progress. Only after a careful review of this case did the school staff realize what the sequence of events had been.**

In this case, a careful sharing of data all along might have allowed the therapist to use the teacher's departure as a basis for helping the boy work through his feelings about his father's desertion. A valuable opportunity was lost and the educational progress was blocked.

THE FOREGOING describes a set of expectations for basic procedure in the rapidly enlarging areas of mutual effort by professional persons in behalf of children with learning and behavior problems. Much of what is emphasized is being carried out in a few places but the efforts vary widely in consistency and in clarity of purpose.

# integration of the family into the CHILD PLACEMENT PROCESS

SIDNEY Z. MOSS

The customary emphasis in child welfare services has been on the child, but child welfare workers are now becoming concerned with the family as an important focus for service,[1] for the sake of the child. The goal of child welfare services is to keep children in their own homes whenever possible. When children cannot be kept in their own homes, their own families must be involved in all aspects of their placement—whether this is to be in an institution or in a foster family—if the crucial ties between parents and child are to be strengthened or maintained. While I will here discuss institutional placement, my emphasis on involving the family is equally applicable to foster family placement.

In current child welfare practice, the family is usually involved in the placement, but often only minimally. Too often the family as a whole is not included in the initiation of the idea of placement, in the child welfare worker's evaluation of whether it is desirable, or in the preparation of the child for the coming separation. However, with a family-centered approach to casework the child welfare worker could help the family play an integral part in each step of planning for the child, from the first consideration of placement until his discharge from the institution.

Family-centered casework is based on three theoretical principles:

1. The family is a psychological unit that can be conceived of and treated as a whole.

2. The child's pathology cannot be separated from the pathology in the family.[2] Thus the worker does not attempt to perceive or treat the child as separate from the family or conversely, to see or treat other members of the family as separate from the child.

3. A change in one part of the family may result in changes in other parts and in the whole.

Acceptance of these principles will change the caseworker's perception of the implications of placement and of the roles of the child and other members of the family in the placement.

In family-centered casework the members are interviewed together repeatedly, although individual members or combinations of members may also be interviewed separately. The questions the worker asks are somewhat different from those he would ask if he concentrated his attention solely on the child. For example, when a change occurs in the family structure—through birth, death, or otherwise—he will look for patterns of *family* coping rather than of individual coping.

The placement worker with a family orientation begins his evaluation by considering all the members of the family, not only those who apply for service or who live in the household, but also absent members. If other children are in the home, the child to be placed may ask why *they* are not being placed with, or instead of, him; and the children who remain at home may ask themselves analogous questions and wonder if they too will be sent away soon. Each child wonders why the child who has left was chosen to go and each has his security in the family shaken. The parents too must face such questions. In some

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Based on a paper presented at State University of Iowa, Iowa City, Institute on Child Placement, March 28–30, 1968.

cases, of course, the child who is being taken out of the family may have a brother or sister who has already been placed outside the home, in the same or another setting. Or, it may be that the child being placed has no brothers or sisters. Unfortunately, little is known about the implications of placement of an only child for the child or his parents.

Thus the presence or absence of other children in the family can make a difference in the effect of the placement on the family and on the child. So can such other factors as the age and sex of the other children in the home and whether or not they are full or step brothers and sisters.

Similarly, the size of the family, the number of generations it contains, the sex, age, marital status, and relationships of the other family members also affect the child's and the family's reaction to the placement, their psychological functioning, and the interaction within the family.

After the decision for placement has been made, the worker can help both the family and the child deal with the interrelated necessities arising from the placement: (1) mastery of the loss, (2) adaptation to placement, and (3) use of the experience for psychological growth.

## Whether to place

Before a child is removed from his home there are two stages in the casework process. First the family and the worker must reach a decision about whether or not the child is to be placed. If they decide for placement then the worker helps the family and the child to separate and to prepare to use the placement constructively.

In regard to reaching a decision, if the family initiated the idea of placing the child, a long step has been taken in the placement process—one which may have to be retraced and reevaluated. In joint interviews with all the members of the family, the placement worker can quickly become involved in the family dynamics; he need not wait to hear from each member about himself and the others and how they interact but can immediately observe and feel the true sense of the family. He can learn what the child and the family mean to each other.

Frequently the way the child's parents interact with one another is regarded as the key problem behind the family's or child's dysfunctioning. The worker can be sensitive to the quality of the parents' relationship, but can also see the way the child affects this relationship. He can also observe relationships within the family—between parent and child, the siblings, or representatives of three generations.

Understanding these aspects of family functioning is important, for situations often exist in which pathology in the family is lived through or thrust upon the child. The child may be a scapegoat as a result of the family's projection of all its frustrations upon him. He may be seen as a kind of negative family healer whose placement will save the family or as the sick one who will cleanse the family through his absence. He may be the substitute tacitly agreed upon to take the place of the truly disturbed member, perhaps one of the parents, or his ejection may unconsciously be designed to divert family attention from one member's pathology or from a pathological relationship within the family.

The child himself may carry the basic pathology. If so, family-centered casework can help the child, the family, and the worker to see more clearly the implications of the child's destructive behavior. If the worker believes that placing the child away from home will not be truly advantageous for him or for the family, he can direct the family to the kind of help most appropriate, whether this is to be aimed at one person or the entire family.

When the worker sees the whole family as the client, he is not likely always to see the child as the victim requiring rescue or the parents as overwhelmed and in need of relief from a tyrannical child. He will see the interlocking strengths and weaknesses of every member of the family.

During a series of family interviews, the members of the family repeatedly have to talk to one another about their problems, to feel their reactions to them, and to act out their feelings. In so interacting, a family oneness emerges that may reclaim the rejected child, allowing the family to wrestle as a whole with the problems presented by the presence of the child in the home. For the child welfare worker to work with the family as a whole provides a symbolic affirmation of family unity that may help keep the child at home.

It is important for the whole family, including the child for whom placement is being considered, to discuss together the pros and cons of placement before a decision is made. The child already knows about his family's attitude toward him since for some time he has been living with the idea of being placed, explicitly or implicitly expressed. The opportunity for him to express how *he* feels about this in a genuine encounter with his parents, perhaps for the first time, and for the parents to be confronted with the implica-

tions of removing him from their home, reduces the trauma of the idea for everyone. Dispelling the secrecy allows the members of the family to express their feelings, negative and positive. In doing so they may come to realize that the family will not fall apart when they are confronted with each others' negative thoughts. In many families the members live in fear that their hostile, aggressive thoughts will destroy each other or themselves, that they will lose control of murderous impulses or go insane.

Family-centered casework is not just observation of undisciplined family interaction. The role of the caseworker is extremely important. The worker brings to the sessions organization, control, calm concern, and a promise of help. In focusing attention on the problems in the family rather than limiting it to the child's need for placement, he not only releases the child from the center of concern, but helps the family to define the genuine issues threatening its solidarity and the most appropriate means of dealing with them. Alert to the resources of the community, he may suggest appropriate alternatives to placement, such as intensive casework, outpatient psychiatric treatment for the child or another member of his family, day care, or homemaker services.

Schulman and Leichter have reported on a project in which families were referred for family-centered casework from a child placement agency.[3] Each family had requested placement of a child away from home, and each had been judged by the intake worker of the placement agency as having "some strength" as a family and "marked ambivalence" in their feelings about the requested placement. After extensive family therapy only six of the 70 families decided to go ahead with child placement. And in those six, placement took place "under more favorable conditions than existed when it was first considered."

The project workers concluded that the need for placement was essentially a way of singling out a scapegoat—using the child as a substitute to carry a burden for another person in the family.

Keeping the child in the home with his family is, of course, not always the ideal decision, for there are situations in which the family pathology is too destructive to the child. However, even then helping the members of the family recognize their own feelings about each other can be the first step in helping both the child and family make the best use of the placement.

## Preplacement planning

When the family has decided for placement, the time has come to look at their expectations of the placement and also at the worker's. Each may expect some kind of magic to occur. The child may feel that somehow the parents will change and after a while be able to accept him back in the fold. The parents may feel that their responsibility to the child is ended for the time being and that the agency will change the child or keep him indefinitely. The worker, too, may hope that somehow the placement, in and of itself, will automatically bring about a desired change in both child and family. The family and child usually show marked ambivalence in their feelings at this point. Each wonders whether the placement will really occur after all and the worker wonders, too.

If the worker has examined his own conflict about the separation, he can be helpful to the family and the child in this period. The family and child may react to the coming separation with a great deal of anxiety. They may anticipate the placement with feelings of grief and mourning for their expected loss of one another. If they repress these feelings, the trauma that comes with the actual separation may be intensified.

The professional literature has paid a great deal of attention to the suffering of the child as he leaves his family and his familiar environment. The child is going to be alone while the rest of the family remains together; he is going to an unknown environment which will have unknown expectations of him. With a shattered sense of identity resulting from his often longstanding rejection by his family, he has few inner resources to draw on, and the family's external supports have failed him.

What of the family's reaction to his impending departure? Only recently has literature begun to appear on this subject.[4,5,6] The family begins to mourn its loss of the child.[6] The parents feel that

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not only have they failed their child but also that they have *done something* to him.

The grandparents have analogous feelings of guilt and shame. They feel that they have failed their own child in not preparing him to be a better parent. They may also resent him for having exposed their own inadequacy. Thus the grandparents may side with the child and seek to rescue him. Or they may withdraw altogether from the painful situation. The child's brothers and sisters may also react strongly. If they have not been involved in the family discussions, they may be very confused about their own security and the kind of feelings they should have toward their parents and the child to be placed. While its members are undergoing these feelings of guilt, loss, and confusion, the family as a whole begins to plan to reconstitute itself without one of its members. It begins to redistribute property and privileges and to shift its interrelationships.

During the preplacement period, the placement worker has much to do. If he has a family orientation, he is already aware of the range of problems which must be met at this time and the techniques to handle them. In discussions with the family as a whole he helps the members face the unreality of their magical expectations so that they can see clearly the realistic need for continuing to be involved with the child after placement. The worker enables the members of the family to understand and work through their anxieties about the separation. He helps them evoke and affirm their feelings of grief and loss. He encourages the child and each member of the family, as well as the family as a whole, to express their feelings so that each may know the feelings of the other and feel understood by the other. This process helps prepare both the family and the child to use the placement as an opportunity for growth.

## While the child is away

When the child is placed, the institutional caseworker—who may or may not be different from the placement worker—continues with the family orientation. He and the institution together can provide a supportive framework in which the family and the child can work out the pain of separation. He can help them develop new integrative patterns for growing in relation to each other whether or not they will reunite at a later time.

A family orientation recognizes the importance of the child's daily life in the institution—particularly the cottage life, the child's relationship to the cottage parents and the other children and the various other institution-based relationships in which he becomes involved. For example, the cottage parents may present the child with problems of dual loyalty, especially if they regard the child as a deprived child to be rescued from bad parents. The whole question of the role of the cottage parents in strengthening or weakening the child's relationship to his own parents needs a great deal more attention.

The worker with a family orientation will also be concerned about the relationships that the child develops with the other children in the cottage, for the child gives clues to his family relationships through his behavior with his peers.

Zusman [7] has pointed out certain attitudes and modes of behavior that can be expected of any person newly arrived in an institution. Thus, the placed child has to deal with the shock of being in a new situation over which he has no control, with little understanding of what is expected of him. In addition to being uprooted from his family and familiar surroundings, he is suffering from extreme anxiety and intense feelings of guilt and loss. The institutional bureaucracy further strips away his sense of identity by informing him of regulations that equate him with amorphous others. He feels a societal stigma on himself and his family and this reinforces his feelings of inadequacy. He is now "different" from all nonplaced children, including his own brothers and sisters. The caseworker, the institution, his family, and the outside world perceive his behavior in the light of his new role as a placed child.

The child's parents may also strongly feel a social stigma attached to them as "parents-who-have-placed-their-child"; each family member, in fact, becomes a representative of a "family-who-has-placed-a-child." At the same time the family is expected to keep in touch with the child and reorganize itself without him, keeping a place open for his return and yet closing ranks sufficiently to function adequately without him.

Although institutions have an obligation to keep in touch with each child's family and encourage it to maintain a tie with the child, institutions vary considerably in carrying out this obligation. In the initial phase of placement nearly all institutions severely limit the parental involvement, responsibility, and rights in regard to the child. Subsequently the institution may see the family as playing an auxiliary part: informing it about the family-child relationships and supporting it in its services

to the child. If the institution does not gradually increase the parent's involvement with the child, the parents face another paradox: they are encouraged to plan for the child's return home yet they are given little help in learning to master the responsibilities of parenthood and family life.

## Maintaining relationships

The ideal goal of placement is to enable the child to return to his family. If the institution focuses its attention primarily on the child, further alienation between child and family may occur. The child may have grown in emotional stature and the family may also have grown; yet if they have not changed in relation to each other, the reunion may not work.

Even if the family and the child maintain little direct connection with one another while they are apart, they are not necessarily unconcerned about their relationship. The child may create fantasies about the other members of his family. Often he idealizes his parents, or he imagines that his brothers and sisters are having untold pleasure at home, or he thinks the family has forgotten him.

A child in placement who represses his feeling of guilt about being sent away from home and his grief for the loss of his family will not be able to establish meaningful relationships in the institution. His growth will be thwarted, his symptoms of emotional upset will hang on or be accentuated, and his ego will remain constricted.[8]

How can the institutional caseworker with a family perspective respond to these problems of child and family? His ability to help will depend on a belief in the institution's potential for strengthening the ties between the child and family and on his trust in the family's ability to work for new relationships with the child. With such a positive approach, he can help the family to become increasingly involved with the child—visiting him, writing to him, and taking on more and more responsibility for his welfare. The worker can help to bring this about by working with the parents and child together to help them realize and overcome their sense of guilt, loss, and grief.

Through the repeated interaction in family-centered casework between the child in placement and the other members of his family, each may individually give up the fantasies he has about the others, supplanting them with realities. As adult family members learn to accept the authority of the worker and the institution, they may be able to assert authority more effectively with the child. The worker can provide a new sense of order and direction in the family-child relationship as he sets expectations for each member of the family and holds to them. As he exhibits his trust in the family and child, they may gradually lose their sense of guilt and shame. The worker helps the family strengthen its sense of family identity by supporting both individuality and relatedness. He encourages the family to establish new adaptive mechanisms to prevent the creation of a new scapegoat and at the same time encourages them to keep a place in the family for the child.

Should it be decided the child cannot be reunited with his family, family-centered casework can be helpful in strengthening the ability of both the child and the family to admit and live with the need for permanent separation.

## Discharge and after care

Evaluation and treatment of the family as a whole is extremely important in planning for the child's discharge from the institution and for his care afterwards. Before the child is discharged, the worker must see that the family and child have begun to work out a new relationship. He can find evidence of this most easily not through second-hand reports from family members but through first-hand observation of the interaction of family members with the child. The goal of placement is not to resolve all major conflicts in the family, but rather to help the family and child gain perspective on their relationship and to motivate them to work for a better one.

The family and child will both feel a sense of uncertainty as their reunion approaches. Joint interviews with the caseworker can give them an opportunity to test out their relationships before placement is terminated. As such interviews reduce feelings of anxiety, guilt, and dependency, the child may be more willing to give up the security of the institution to which he has become accustomed for the uncertainty of life in the family to which he belongs. However, after the child returns to the family the need for family-oriented casework may continue and in fact may intensify. The reintegration of the child into the family in a sense creates a new family system with new problems and new defenses, although earlier conflicts may not have been resolved.

The use of the family-centered approach has met with some resistance in the child welfare field, where the child has always been the central focus of attention although the parents have been recognized as a vital force in the child's life. I think that this is

resistance not to change *per se* but to certain aspects of the family treatment method.

The classic casework model is the one-to-one relationship. The family approach represents a break with this model. Because the family is not one person, but a constellation of persons, it requires a different conceptual scheme for evaluation and treatment. In the family approach, with the child no longer the central focus of concern, the worker may feel guilty about deserting the child, for child welfare workers have long assumed a parental role along with their therapeutic role. A family orientation protects the child, but it marshalls the resources of the family to do this rather than depending on the worker.

The child welfare worker may also resist family-centered treatment because of unresolved conflicts with his own parental family. A family-oriented worker must be able to work simultaneously with children and adults and respond to the situation they are in rather than to his own conflicts. He must be able to handle, in a disciplined way, the discharge of people's feelings not only as they are directed to him but also as they are directed to others in family interaction.

To adopt a family orientation, the worker needs the support of his agency or institution. But bureaucratic organizations, like people, find change difficult, especially when it threatens loss of bureaucratic control.

The family also can be resistant to family-centered treatment. Its members may feel that the placement of the child relieves them of responsibility and so reject the intrusion of the agency. They may also resist the idea that they all have had a part to play in the problems leading to the child's placement and must all work together to resolve them. Some families are so resistant that to see all the members together the worker must go into their homes to work with them there.

THE FAMILY-CENTERED APPROACH offers a useful method for dealing with placement issues. In calling for the involvement of all members of the family in all aspects of placement, it evokes untapped strengths from within the family. It provides a technique for learning about the parents' capacities for parenthood and the resources of the whole family; for determining the meaning of the placement request; for enabling the child and family to work through the separation trauma; for enabling important shifts of relationships to take place within the family; for supplying a solid base for determining whether or not the child and family should be reunited; and for insuring post placement experiences for the child that are conducive to healthy growth.

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**From the web of interconnected factors which shape youthful behavior, two major themes appear again and again to guide national efforts to prevent delinquency. They are: (a) The need to involve young people with greater meaning, respect, and responsibility in those affairs of society which affect them, and (b) the need for our institutions to produce better education, strengthen family life, improve opportunities for employment, and make the activities of law enforcement and individual and social services more relevant and more accessible to those who need them most.**

***President's Commission on Law Enforcement and Administration of Justice, Task Force on Juvenile Delinquency: Juvenile delinquency and youth crime. Washington, D.C. 1967.***

# STUDENT VOLUNTEERS as GROUP LEADERS in ELEMENTARY SCHOOLS

MAE SKJOITEN • ROBERT M. BARTLETT

For the past 2 years junior college students have served in the public schools of Thief River Falls, Minn., as volunteer leaders of directed play activities for groups of four to six children who have had some difficulty adjusting to elementary school. Through crafts, quiet games, hikes, woodwork, playground, and conversation, the activity groups are designed to help the children develop positive feelings toward themselves, toward others, and toward school. These groups are the crux of a program jointly operated by the public school system and the Northland State Junior College in Thief River Falls, and the Northwestern Mental Health Center in Crookston, Minn., to identify and alleviate potential difficulties in school children before they reach a crisis. In the fall of 1968, the program began its third year with new junior college volunteers as well as with new staff leadership.

In most of our school systems, children who show extreme difficulties in adjustment to school occupy most of the school social workers' time. They include chronic truants, children who disrupt classes by acting out their hostilities, and severely withdrawn, apathetic children. While social workers encourage the parents of such children to work with the school in aiding the child before he reaches adulthood, often this individual help comes only after the child's problems have become complex and difficult to reverse.

Many children, however, have adjustment problems that are less severe and more readily reversible, but—because of the demands from other children—school social workers are unable to give them much individual attention. In an attempt to reach more of these students and to prevent more serious problems, an activity group program has been established in the Thief River Falls schools. It began with five groups of four to six children each in the school year of 1966–67. Similar groups have been established in each ensuing year.

The group work consultant at the mental health center and the elementary school social worker serve as directors for the program. Elementary school teachers are asked to refer children in their classrooms with adjustmental difficulties to the social worker. She follows up each written referral by discussing with the teacher the goals of the activity group and how it can help the child. The teacher rates the child on a behavior scale when he enters the group, and after 3 and 6 months. Ratings help the directors recognize changes in the child's attitudes and determine the point at which a child has progressed enough to discontinue participation in the group meetings.

The groups usually consist of children of the same age and sex, but not necessarily from the same classrooms. In most cases, the groups are not restricted to children with the same types of needs. However, extremely aggressive and extremely passive children are generally not put in the same group.

Children in the second through the fifth grades meet during school hours in supply rooms, nurses'



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offices, gymnasiums, and on playgrounds. While lack of adequate space at the schools is a disadvantage, the directors have not tried to hold regular meetings outside the school because the goal is to provide successful "in school" experiences. Younger children attend two 30-minute meetings and older children one 1-hour meeting each week. Each group is assigned two junior college volunteers. These volunteers plan the activities and work together to help the children in their group learn, develop, and have fun. At least one of the volunteers is the same sex as the children in the group.

The majority of group members are children who have had limited experiences in group play, shy children who are uncomfortable in a large classroom, aggressive children who need to channel their energies, children who do not achieve in their school work up to their capacity, children who need more contact with other children and adults, children who need to learn how to cooperate or how to express themselves, and children who need to feel more important. Some children with obvious school adjustment problems are included in the groups to supplement the social worker's efforts to help them and their families individually.

The school does not regard the child as deviant because of his membership in the group but merely as a child who needs extra experiences for normal social development. Children often report to the class that they have fun in "group." In general, the children regard inclusion in a group as a privilege.

All the groups are geared toward giving the child an experience of success. Many children gain confidence from the relationship they build with the volunteers, often the first adults outside their families with whom they have become close. Some children benefit from the opportunity to try new activities in a small group. For example, one boy would not join in gym class activities. After several meetings with his group, he began to join in the group games and eventually he started to participate in gym classes.

By providing a variety of activities, the volunteers help some awkward children become more confident. For example, Jane had trouble with crafts, but was quick to solve puzzles. She gained a measure of success by showing her group how to do certain puzzles.

Group meetings also afford a way to channel the energy of an aggressive child into healthy recreation. The child learns to share, gains a sense of belonging and acceptance, and develops leadership.

## The volunteers

Northland State students are recruited as volunteers by the junior college counselor. Interest—not experience—is the only requirement. Most of the volunteers, however, have been leaders in school clubs, church groups, Boy or Girl Scouts, or similar organizations. Ten students participated the first year and 12—eight boys and four girls—the second year.

Despite a lack of formal training, junior college volunteers have many assets in working with children. They bring with them enthusiasm, warmth, and creativity. They provide the children with a role model of a "big brother" or a "big sister." They are dependable and generally consistent—qualities of the utmost importance in working with a child.

Before beginning their work with the activity groups, volunteers attend three inservice training sessions sponsored jointly by the school system and the regional mental health center. The center's group work consultant conducts the sessions and demonstrates techniques of group leadership. The school social worker helps direct the discussions. These sessions are designed to increase each volunteer's confidence by—

1. Clarifying group purposes and goals. Without guidance the junior college student may set unrealistic goals for his group; he may try to reform the children; he may want to help them "too much." In place of goals that may lead to disillusionment, the directors suggest that the volunteers set limited goals. They stress the importance of establishing good relationships with the children and the value of brief, successful experiences within the groups.

2. Encouraging the volunteers to use their own ideas, to find commonsense ways to deal with the group, to be creative, and to be independent. The directors point out that a good volunteer is willing

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**Mae Skjoiten, and Robert M. Bartlett, right, initiated the project described here when she was school social worker in Thief River Falls, Minn., and he was group work consultant, Northwestern Mental Health Center, which serves seven Minnesota counties. Mr. Bartlett became social planning assistant with the Social Service Department, Calgary, Alberta, Canada, September 1, 1968.**

to consult social workers, teachers, and other volunteers when he needs help.

3. Explaining some basic principles of group work to give the volunteers a better understanding of how to help children adjust.

The program has found that college students who show enough interest and responsibility to attend these sessions are usually effective group leaders. In the few cases where a lack of leadership ability or interest becomes apparent during the training period, the volunteer has been directed into another role. For example, in the first session it became apparent one girl had volunteered as a group leader for extra class credit. She earned the credit she wanted by preparing a file of active games that the group leaders could use.

After the volunteers begin meeting with the children, they attend biweekly group consultation sessions with the school social worker and group consultant. The sessions provide a forum for the volunteers to continue to gain more understanding of group work, to share ideas, to support each other, and to resolve problems of group leadership.

Each year one of the first concerns the volunteers bring up in their consultant sessions is how to plan group activities in a way that will lead the children to begin to discipline themselves.

Volunteers are then encouraged to tell each other about the ways they are dealing with this problem. In one group of shy girls, the volunteers suggested that they needed a child as "leader-helper." The girls decided to rotate the leadership within the group by electing a different leader each week. In this way, each of the children experienced the leader's role—a role they would not accept in the larger classroom. When the success with the children who served as group leaders was reported in the consultant sessions, several volunteers adopted a similar plan of rotating leadership among their group members. In one group, the child leader helped the volunteers; in another, he was in charge of activities for the day; in still another, the child leader was responsible for preparing and serving a fruit drink. By electing the leader, as most groups do, the children learn to accept responsibility and to give it to others.

Some groups decide to become "clubs." Membership in the clubs gives children a feeling of status. One boy commented, "Now I have something to belong to—just like my older brother." Building a clubhouse was a unifying project for one group of boys.

Volunteers use their own ingenuity and resourcefulness in working out challenging things for the children to do. For example, the volunteer leaders asked the children in their group to act out a "words in action" picture that showed a shoe clerk, a mother, and a girl. Sue—a shy girl who had not talked in the classroom or in her group unless asked a direct question—suggested that there be two clerks so all the children could take part. The other girls accepted her idea and Sue took the role of one of the clerks.

Two other volunteers found the use of a tape recorder increased interest and participation in a group of quiet girls.

The school social worker handles administration and supervision for the activity group. She is available for consultation whenever the volunteers want to talk to her. Periodically, she "drops by" after a group meeting to discuss problems they have just encountered.

Each principal must approve the group's programming and arrangements, as with all other regular school activities. Principals have allowed groups to meet during school hours and have provided space even in overcrowded schools. After the volunteers made and submitted plans, principals approved field trips to the junior college, the newspaper plant, a bakery, and other places within walking distance of the schools.

## Successful experience

The evaluation of a preventive program is at best difficult. How do we know if the program has helped to curb something that has not really begun? We cannot know, for sure, but we believe that the program has met some of the goals set for it by providing a successful school experience for a number of children. Teachers report that most of the children who attend the activity groups are enthusiastic participants.

Because the activity groups meet as part of the regular school day, parents are not asked to give permission for their child to attend the weekly meetings. However, a letter explaining what the groups do is sent to all parents; it invites them to contact the school social worker for further information. Only two of the 50 parents contacted by phone and in person in an informal survey asked that their children be taken out of the group.

Many of the parents have commented favorably on the projects. For example:

"John calls group day his 'good' day."

"Mary thinks speech and group are the only things she likes in school."

One mother, whose child was assigned to a group the first year, offered her services as a volunteer leader the second year.

Groups have problems, of course. One 9-year-old boy's disruptive behavior threatened to destroy his group. He had been equally disruptive in the classroom. The volunteers were unable to help him modify his behavior—perhaps because he was not ready for a group experience or the program participants were not well enough prepared to deal with him. He was not assigned to a group the second year. Instead the social worker found a "big brother" for him.

Perhaps the biggest problem a school faces in implementing a preventive program is that of gaining approval from the teachers. When the teachers are informed and involved, they become far more receptive to referring children to the activity groups. In Thief River Falls schools, teachers are now helping with overall plans for the groups and with evaluation sessions. Enthusiastic teachers have been especially valuable in bringing the more skeptical teachers into the program.

Because the group activity project is experimental, it can only serve a maximum of 30 of the 1,500 children in the four elementary schools in Thief River Falls.

There seems to be little feeling among children, parents, teachers, or administrators that the children who participate in group activities are put at a disadvantage by missing classwork. On the contrary, the children seem to have no trouble making up the work missed in the hour they are out of their regular class. Some of the teachers have expressed the opinion that for children who are far behind their classmates, the hour in the small group may be more important than the work done in class. Children leave classes for many reasons each day, and most teachers handle the absence for activity groups in the same way they handle absences for music, speech, and other special classes.

A few teachers do not support the activity groups; that is, they make no referrals of children for the activity groups. However, the number has declined as the teachers have come to understand the goals of the groups.

We believe that the Thief River Falls experience in using volunteers as activity group leaders has demonstrated a positive approach to helping children adjust to school. Although many mistakes were made in the beginning, the program has undoubtedly given children experiences of success early in their school life. By keeping the school from being a completely frustrating experience for children who are finding it difficult, the program may prevent the compounding of problems to the point of eventual failure. Thus the program may be regarded as a model of preventive social work.

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**The value of truth runs a broad gamut—from individual interest in not telling lies and in personal sincerity, all the way to the frontier aspect of the endless search for knowledge and understanding of the universe. Truth is as great as trying to unlock the mystery of life, and as simple as not cheating in school.**

**The value of truth, recharged and accepted dynamically [by society as a whole], would automatically bring a forceful change in education—in the status of teachers, perhaps also in educational content and method, and certainly in the relation of schools to communities.**

**We do not have to discard education's lesser utilitarian goals to realize that increased capacity to approach and to comprehend a larger fragment of limitless truth is one great objective of life itself. This objective is as great and joyous for a child in primary school as for the advanced practitioners and pioneers in industrial, government, or academic life. . . .**

***Adolph A. Berle, Jr., "The Transcendental Margin," in* State Charities Aid Association Viewpoint, *Fall 1962.***

# MOTHERS' WAGES

# ONE WAY TO ATTACK POVERTY

DAVID G. GIL

During recent years an awareness of poverty, its high social and economic costs, and its disastrous consequences for those directly affected by it, as well as for society as a whole, has spread throughout the nation. This increasing visibility of poverty has given rise to mounting dissatisfaction with the public welfare system and especially with the program of aid to families with dependent children which was designed more than 30 years ago as one of the nation's defenses against poverty. In response to this general dissatisfaction with the failure of public welfare programs to deal adequately with the massive problem of poverty, a variety of far-reaching proposals have been formulated by economists and other social and political scientists and by political leaders in and outside the Government. These proposals include a negative income tax, a guaranteed annual income, children's allowance, Federal administration of public assistance with nationwide uniform standards, a more comprehensive social security system, and various combinations of such mechanisms. [See "A Focus on Children of the Poor," by Vera Shlakman, CHILDREN, July–August 1967.]

The general objective of all these proposals is to assure everyone an adequate share in the affluence of American society as a basic right to enable all people to live decently during all phases of their lives, regardless of economic trends and the many risks connected with age, ill health, and physical, emotional, and social handicaps. This objective has been endorsed in recent years by Governmental commissions such as the National Commission on Technology, Automation, and Economic Progress [1] and the Advisory Council on Public Welfare [2] as well as by business, labor, religious, professional, academic, political, and private groups, and national leaders.

Each of these proposals may have philosophical, political, and technical assets and shortcomings. It is perhaps not very important which proposal or combination of proposals is eventually adopted as long as the ultimate objective is accepted as national policy and is translated into legislation that will eliminate poverty from our society. In proposing herewith yet another approach to combating poverty, I do not mean to imply that this alternative is without shortcomings. I am merely adding it to the array of existing options as one that seems to have some unique philosophical and technical merits.

The approach I propose may be designated as Mothers' Wages, or Social Security for Motherhood. It is based on the premise that society has a stake in, and an ultimate responsibility for, the rearing of children, since on this function depends the continuity and survival of society. The child's family is in a sense serving as society's agent in carrying out this function. If this is so, then any work performed in bringing up a child constitutes an important societal task for which society should compensate those who have to disengage from, or to stay out of, the labor market to perform it. For society to accept the ultimate responsibility for rearing the next generation of citizens and to compensate mothers for their investment of time, energy, and work in assuming this responsibility would be quite consistent with 19th and 20th century social and legal developments concerning the status of children. Indeed, unless society compensates mothers for their voluntary-yet-forced withdrawal from the labor market and for their assumption of the essential tasks of child bearing and rearing, it is actually relying on "slave labor" in exploiting women's biological roles and psychological tendencies.

Society has gradually accepted the responsibility for rearing and socializing children who are under the supervision of persons other than their biological or adopted parents. No one today seriously questions the appropriateness of compensating teachers and in-

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stitutional workers for their investment of time, energy, and work on behalf of children assigned to their care and few question the appropriateness of compensating foster parents, although the compensation may be far from adequate.

It would seem, therefore, that society should pay an appropriate wage to every mother and expectant mother for as long as child bearing and rearing tasks keep them outside the labor market, whether or not by choice. The level of the mothers' wages should be fixed by Federal law to correspond at least to the minimum wage under the Fair Labor Standards Act, and thus every mother would be assured an income well above the poverty level. If wages were computed for only 8 hours per day, 7 days per week, a mother would receive about $90 per week, or $4,680 per year.

Under such a system mothers' wages would not vary in relation to the number of children under care, since their purpose would be to compensate the mother for staying out of the labor market to invest effort in a societal function. The number of children in the mother's care would not change this context. The wages, however, would vary in relation to the extent to which the mothers did or did not participate in the labor market. A mother who undertook part-time employment or self-employment would receive mothers' wages on a prorated basis. A mother who engaged in full-time employment would receive a fixed fraction of the mother's wage, in recognition of the fact that child rearing involves an around-the-clock, 365 days-a-year, stand-by maternal responsibility.

The age of the children in a mother's care might be another factor in varying the wage level since the time commitment a mother must make to child rearing tasks varies with the age of the child. Before the child enters school, the mother's investment in child rearing is total. From that point on, under normal circumstances, the mother's investment of time and effort in child rearing decreases and she may no longer need to stay completely out of the labor market.

Since the only criteria for paying mothers' wages and determining their amount would be the status of motherhood or expectant motherhood and the extent of attachment to the labor market, all mothers who qualified under these criteria would be entitled to compensation irrespective of their legal and financial status. Thus mothers would not be stigmatized for receiving such wages. Marital status, property, and other sources of income would be disregarded in determining eligibility. However, since the mothers' wages would be taxable income, regular taxation mechanisms would return excess income to society.

Mothers' wages as proposed here are conceived of as an entitlement related to a specified societal context, motherhood, and disengagement from the labor market. Thus conceptualized, a program of mothers' wages fits the social security model and the Social Security Administration becomes the most appropriate and economic government mechanism to administer it. To obtain her wage, an expectant mother would register her claim at a social security office, and checks would be issued to her automatically as long as she continued to be eligible. The cost of the program could be met partly through raising the base for social security deductions and partly from general revenue, which would increase because mothers who received societal wages could not be claimed as dependents for income tax purposes.

It would seem to be desirable to link the mothers' wages plan proposed here with a system of children's allowances to which all legal minors would be entitled. This combination of programs would assure proportionally larger income for larger families.

I am aware that a proposal for mothers' wages raises many complicated issues requiring thorough exploration. Foremost among them are its fiscal and economic aspects, its consequences for taxation, income redistribution, and economic expansion, and its effects on (1) the family, especially the role of the father, (2) the birth rate, and (3) the role of women in society, and in the work force. However, it would be unrealistic to expect easy solutions to as complex a problem as poverty in America. People who are discouraged by the complexities involved in eliminating poverty should remember that preserving the status quo of a society divided into affluent and poverty-stricken segments might be even more complicated a task than bringing about social justice.

[1] National Commission on Technology, Automation, and Economic Progress: Technology and the American economy. 1966.

[2] U.S. Department of Health, Education, and Welfare, Welfare Administration: Having the power, we have the duty. Report of the Advisory Council on Public Welfare, June 1966.

# a HOSPITAL SOCIAL WORKER in a MATERNITY and INFANT CARE PROJECT

SAMELLA B. EVERETT

Two years as a social worker in a clinic and hospital-based maternity program serving low-income women and girls have made me acutely aware of the importance of the concepts "comprehensive care" and "public health approach" in providing service to such patients, especially when those patients are teenage unmarried mothers. By comprehensive care, I mean taking into account all aspects of the patient's life in dealing with her medical problems;[1,2,3] and by public health approach, I mean placing emphasis on early identification of problems and preventing their recurrence through the application of knowledge about the precipitating factors.

When the Chicago Board of Health established a maternity and infant care project in 1964 with a grant from the Children's Bureau, it contracted with a number of medical schools and voluntary hospitals to provide prenatal and obstetrical service for the high-risk mothers and infants the project was designed to serve. Among these were the Passavant Memorial Hospital and the Northwestern University Medical School Clinics, which provided the prenatal outpatient clinic care for the hospital. As one of the professional social workers of the combined departments of social work of Northwestern Medical School Clinics and Passavant Memorial Hospital, I was assigned the responsibility of planning and carrying out the social service program for the patients who would be receiving care at the prenatal clinic and the hospital under the maternity and infant care project.

The patients in the maternity and infant care project were all women and girls of low-income families who, on the basis of physical or social criteria established by the Board of Health, were at high risk of suffering a pregnancy casualty or producing a subnormal child. They included women with medically complicated pregnancies, women 35 and over in their first pregnancies, women 40 and older regardless of the number of past pregnancies, pregnant girls 15 years of age and younger, and emotionally or mentally disturbed pregnant women. The clinic staff included two obstetricians of the hospital staff, two residents in obstetrics, two nurses, a social worker (myself), and a social work assistant (a college graduate who had no formal training in social work). In addition, public health nurses from the Board of Health were available for home visiting.

## Knowing the patient

Incorporating the public health approach into the social service aspects of comprehensive care meant to us that the social workers on the clinic team would need to know who the clinic's patients were, what social and personal problems they had, what further problems could be anticipated, and how these might be prevented. Therefore, my assistant and I proceeded to interview all new patients to determine which ones needed our special help or had problems of which the medical staff needed to be aware. We recorded a social summary on each patient interviewed, including background information, our diagnostic impressions, and our plans for dealing with whatever problems had been revealed. Copies of these summaries were filed with the clinical chart and with the patient's social service record. Copies were also sent to the hospital's inpatient obstetrical service and to the Board of Health, which had ultimate responsi-

bility for the well-being of the patients in the maternity and infant care project.

One of our major responsibilities was to see that the medical care could and would be used to the best advantage of mother and child. Too often the unsophisticated patient seemed to look on routine checkups in pregnancy or a postpartum visit as a waste of time. Sometimes this meant we repeatedly had to explain to the reluctant patient the importance to her future health and to the health of her child of giving the physician a chance to detect physical problems early. Very often, the task was more complicated—when severe emotional problems or practical obstacles imposed by poverty interfered with the patient's ability to carry out the doctor's instructions.

But the interpretation had to be two way, for the other members of the team had to be helped to understand the patient's difficulties and ways of communicating. As this occurred, the physicians seemed to gain a better understanding of the kind of service a social worker could provide.

## The older patients

At first I interviewed all the patients under 21 and my assistant interviewed those over 21. Many of the younger patients were reluctant to be interviewed by a social worker. On the other hand, the older patients, especially those who had made poor life adjustments, were eager to see the worker. They often went to the other extreme and expected to unload all their problems onto the social worker for some sort of magical cure. They requested tangible service such as carfare to and from the clinic or a homemaker to take care of their children while they were hospitalized—realistic requests that usually could be met either by the clinic itself or the Board of Health maternity and infant care project, or by arrangements with community agencies. But often, if the social work assistant met their requests for tangible service, the patients became more hostile and demanding, evidencing a more elaborate need. They complained about the many diffuse problems in their lives and showed overwhelming needs for intensive help with their emotional or environmental problems—help our small staff and the available community facilities could not always give them.

Therefore, deciding that it was ill-advised for us to stir up feelings that we could do nothing about, we discontinued routine social service interviews with the older women and instead informally let each one know that a social worker would be available whenever she had a specific problem she wished to discuss. Each was given a card bearing my name and asked to call me for an appointment if such were the case. Whenever a woman followed through with this suggestion, we tried to help her work on the specific problem she came in about.

**In one instance, a mother asked me to find her adequate housing. I acknowledged her desire to place this responsibility on me but recognized that if I accepted it, I would be letting her know that I felt she was incapable of effectively handling the situation. I indicated to her that she could do as well as I, if she considered various factors such as the size of her family, the area where she wished to live, and the housing problems she must refuse to accept. I reminded her of her need not to sacrifice her standards for change which might later necessitate another move. I helped her consider various resources and encouraged her to seek help from relatives in an interdependent rather than a dependent manner. After she successfully solved her housing problem herself, this mother was able to move into a working relationship with me, and we began to work toward solutions of some of her other problems.**

**Some months after the mother had discontinued her regular contact with me, she came to the clinic unexpectedly. She was relaxed and for the first time did not present a disheveled appearance. She embraced me warmly and began to thank me for all that I had done for her to help her find her way out of "a bag" she had felt she would never break through. She had separated from her common-law husband who was keeping her in a state of anxiety with unkept promises to marry her, she had moved to a more adequate apartment near her sisters who were helping her care for her children, she was attending the cardiac clinic regularly for the treatment of hypertension, and she was planning to seek employment when well enough. She expressed a feeling of satisfaction in being able to plan her own life and at not having to depend on a husband, boyfriend, relative, or even me to plan for her.**

We had ready access to the medical school's psychiatry clinic for consultation regarding patients with severe emotional problems. However, we had to refer some highly disturbed women back to the Board of Health to arrange for their delivery in another hospital where psychiatric facilities would be available because our patients had no access to psychiatric facilities during confinement in Passavant Hospital. The Board of Health also made such transfers for women whom we suspected might suffer from postpartum depression.

## The teenagers

We continued the policy of requiring every patient under 21 to have an interview with the social worker, and for some time I conducted these screening interviews myself. Some of the girls were very young—one was only 11 years old. Most of them were unmar-

ried. Before interviewing them, I had to reexamine my own feelings about girls who become pregnant out of wedlock and to recognize the difficulty of bridging the social gap between a middle-class, adult, professional person and an economically deprived teenager from the slums. I came to see the paradox in a society which tends to regard sexual intercourse outside of marriage as all right but getting pregnant from such behavior as wrong and to understand the resulting confusion in young people's minds as to what is appropriate behavior.

In their discussions with me, the girls revealed many reasons for having become pregnant. Many had done so in a conscious effort to prove their womanhood; others, in a rather unconscious rebellion against their parents. Nearly all were under great psychological stress at the contemplation of an impending motherhood for which they were ill prepared economically, socially, or emotionally. And to this stress were added the normal strains of adolescence and of poverty. The result was usually intense anger, with themselves for the state they were in and with me as a productive member of society.

When a girl was unable to direct her anger outwardly in expressions of hostility, she usually directed it inwardly, transforming it to hopelessness, apathy, and deep depression. Working with consultation from a psychiatrist, I tried to alleviate such feelings by helping her recognize and express her anger. If she showed signs of having some "fight" in her, I tried to help her to use this energy to fight for what she needed and wanted rather than to fight against people who presented obstacles. For example, if she felt she should transfer from the school she had previously attended where she would be marked with a social stigma, I would help her to contact the office of the district superintendent of schools, who approved such transfers in recognition of the need to alleviate emotional deterrents to learning.

## Overcoming distrust

Most of these girls needed help in seeing clearly what they wanted and in deciding how best to attain it. Many of them knew little or nothing about the resources available in the community to help them with particular problems. Moreover, they distrusted the community agencies as they distrusted me and all adults; they felt that the world of adults—society at large—was at once responsible for their predicament and punishing them for it. When they first came for the interview, they seemed to feel that my only interest in them was to arrange to take their babies for placement in foster care or adoption and to give them a lecture on birth control.

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I learned that many of the usual interviewing techniques of social casework were not useful in building a relationship with these suspicious, rather nonverbal young people. Instead of relying on the customary technique of asking them how they felt about their situation, I had to help them find the words to tell how they felt. For example, I would begin the interview by telling them who I was and how my services were related to their care during pregnancy. I would tell them that usually when women become pregnant they have some feelings or experiences they want to talk about with others, but may have difficulty doing so. I would remark that it must be hard to hold so much inside and that perhaps she would like to tell me how she felt when she first learned of her pregnancy, how she told her parents, and how they reacted.

My efforts were directed to helping these teenage expectant mothers view their situation realistically, in relation not only to their own needs and rights but also to the needs and rights of the coming baby. To underscore the importance of learning to be a good mother, I encouraged them to read Dr. Benjamin Spock's "Baby and Child Care," and Dr. Arnold Gessell's "Child Behavior." At the end of the interview, I told them that I would be readily available to them should they wish to raise questions at any time. To emphasize this fact, I gave them a card containing my name and office telephone number and told them to call me between their clinic appointments if they wished. To those girls who seemed especially in need of emotional support, I also gave my home telephone number so that they could telephone me when the clinic was closed if they felt the need. A few did so and seemed greatly appreciative of this support. They did not abuse the privilege.

As the girls began to realize that I was interested in them and did not wish to take their babies away, they became more relaxed. Many came back for further interviews. Sometimes a girl would bring along her mother, father, or even the father of her expected child. In such an instance, I always welcomed the opportunity to talk with the person who came along, for I knew the unborn baby was affecting his or her life.

Usually the girls' parents at first resisted talking to me. They felt ashamed and seemed to expect me to reprimand them for their "failure" with their daughter. Often my opening remark would be: "It must be difficult for you to have worked so hard to make life better for your daughter and then to see something like this happen to her that will expose her to the kind of life you sought to shield her from." Nearly always the response came in the form of tears and outpourings of emotion.

Similarly, the coming baby's father seemed to expect me to lecture him on his wrongdoing. I tried to show that I approved of his desire to accompany the girl to the clinic and to talk about what his responsibilities as a parent would be other than contributing to the child's support.

## Adoption

Among professional persons the subject of adoption has its controversial aspects, especially in relation to babies of unmarried, poor, black girls. Some say that to leave a baby with a mother who is poorly equipped to care for him can only result in physical and emotional deprivation of the child. Apparently to them the problem of meeting the needs of both mother and child seems so overwhelming that they would remove the symptom—the child born out of wedlock—from sight. They see the only solution in expending greater efforts to increase the now scarce resources for the adoptive placement of black infants.

Removing the baby may indeed help the young unmarried mother to cope better with the practical problems of daily living. But what does this do to help her gain a better self-image and become a constructive member of society? Probably nothing—unless a caseworker continues to work with her after she has given up the child to help her meet her social and emotional needs and to deal with her feelings of loss and guilt. Few agencies provide such help.

Most of the girls who came to our clinic were from cultural backgrounds in which unmarried mothers are expected to keep their babies. Many of them seemed to be afraid that I would put pressure on them to relinquish their rights to their babies. Therefore, only when a girl expressly requested placement of her baby or revealed some ambivalence in her feelings about keeping him did I suggest that she might consider adoption as a partial solution to her problems. If she revealed, directly or indirectly, that she did want to give her baby up for adoption but felt guilty about this, I helped her work through her feelings and pointed out the advantages that relinquishment would bring to the child as well as to herself. I interpreted her wish to have the baby adopted as a manifestation of love—a desire to protect her child by giving him a home with two loving parents and a secure future. If she finally decided for adoption, I then made an appointment for her with an adoption agency. All arrangements for the placements were completed during the prenatal period, thus minimizing confusion and uncertainty at the time of delivery.

## Individuals and groups

After several months of experience with these young expectant mothers, it became clear to me that for many of them the chief need was to have at hand a warm, understanding, empathic adult to whom they could bring their problems and who could intervene in their behalf with other agencies. It seemed to me that my expertise in social casework would be used to best advantage if I concentrated on intensive work with fewer patients, specifically those who seemed especially distressed and who showed some signs of being able to respond to treatment. Since my assistant was a warm, understanding, empathic adult, I trained her to carry out the preliminary interviews with all teenage patients and to call to my attention girls who showed signs of emotional confusion or depression or faced severe blocks in communication with their parents.

After interviewing a confused or depressed girl, I reported my impressions to the obstetrician and, when it seemed necessary, referred the girl to the psychiatry clinic for diagnostic workup and recommendations or treatment. In most instances, the psychiatrist referred the girl back to me to provide the recommended treatment but offered continued consultation. In general, the psychiatric consultant supported my belief that the girl needed a relationship with a mature maternal therapist who would attempt to control her behavior and, when necessary, would help her to do so—for example, by telling the patient what was or was not appropriate behavior

in the hospital and how she could or could not act during her period of confinement.

Early in the program, I recognized that most of the girls wanted to be good mothers, but that many of them had no one to teach them how, either because their own mothers were out of the home working, were confused about their dual responsibility of mother and grandmother, or were still struggling to understand the role of a mother in their chaotic, crisis-oriented community. The director of the combined social work department of Passavant Hospital and Northwestern Medical School Clinics and the nurse supervisor of the hospital obstetrical services shared my feeling that our teenage patients could profit from attending classes concerned with family life education, health principles, and baby care. Therefore, we worked out an agreement with the American Red Cross to provide such classes, but these classes were poorly attended. The girls showed little interest and said they could not afford the carfare to get to the center where the classes were held. Later, the obstetrical nurse supervisor developed a plan to provide mothers' classes during clinic sessions in a conference room adjoining the clinic. Because the classes were loosely structured, the girls could attend them while they waited for the call to be examined. These classes were well attended. Occasionally, a girl would bring up in class a problem revealing her need for further social work help, and when this occurred the nurse supervisor would refer the girl back to me.

## Reaching out

Although my assistant and I did not reach our goal of interviewing all the young girls who came to the clinic and at least introducing ourselves to all the older women before their confinement, we did have some contact with 75 percent of the patients who attended the clinic during the 2 years I was there. Of the 148 teenagers who gave birth at the hospital during 1966 under the maternity and infant care project, only 19 had not been seen by one of us before delivery. A few of those we missed were not known to the hospital until they arrived for delivery through the emergency room; the others came to the clinic at times when our appointment schedules were full.

Since the hospital admitting office informed us of all deliveries and since the social work assistant visited the obstetrical floor of the hospital daily to learn how the patients were adjusting, we did have an opportunity to find out whether any of those patients whom we had not seen had problems needing our attention as some did. Some of these patients were for the first time beginning to realize the seriousness of the situation they were in and were in need of emotional support.

At the time of the postpartum examinations, we again offered our services to the patients, especially the young unmarried mothers, to help them release their feelings and modify attitudes that were obstructing their chances of meeting their needs in a manner conducive to self-respect. We also tried at this time to help the girls understand and accept their sexuality and to recognize their conflicts around sex and its role in their lives. In these interviews, we often discussed the meaning of birth control—clearing up some of the patients' misconceptions about it—but we never urged the patients to accept the family planning service that was available at the clinic unless there were medical indications for doing so or they had specifically expressed a desire to have the service.

Throughout all our social work interviews—in whatever stage of the maternity process they occurred—our goal was to help the patients to view realistically their situation and the responsibilities they faced in motherhood and to help them overcome whatever obstacles lay in the way of their meeting these responsibilities. To meet this goal, I felt, was implied in the clinic's obligation to provide *comprehensive* maternity care.

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[1] Lesser, Arthur J.: Accent on prevention through improved service. *Children*, January–February 1964.

[2] Close, Kathryn: Giving babies a healthy start in life. *Children*, September–October 1965.

[3] Swallow, Kathleen A.; Davis, George H.: 645 days of maternity and infant care. *Children*, July–August 1967.

a visitor from Israel reports her impressions of . . .

# PRESCHOOL PROGRAMS for DISADVANTAGED CHILDREN

**SYLVIA KROWN** *Research Psychologist, Hebrew University, Jerusalem, Israel*

Late in 1967, I visited the United States to observe preschool education programs and the new methods being used to meet the social and educational problems of culturally deprived children. My hope was to find ideas applicable to similar problems in my own country, Israel. My visit came about in connection with research being done at the Hebrew University in Jerusalem on the "effects of heterogeneous grouping and compensatory measures on culturally disadvantaged preschool children in Israel." The study has been made possible by a grant from the U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, using counterpart funds.

My visit took me to model schools, early childhood centers, hospitals, universities, Headstart centers, Montessori schools, and Government offices. The cities I visited included New York, Syracuse, Cleveland, and Washington, D.C. The observations that follow are derived from these visits, from the proliferating literature on the subject, and from my own experience in work with preschool children. Not all of the observations have been validated, but research is underway in many areas.

There has obviously been great ferment in thinking in the United States concerning the problems of disadvantaged children among people in the social sciences, education, politics, and other fields. Many methods of solving or easing the problems have been proposed, and many have been tried. Much questioning has been going on, which has led to clearer thinking, though definitive answers are still elusive.

One of the most controversial issues among preschool educators concerns the form educative measures to help preschool disadvantaged children should take. Should the accent be on making up cognitive deficits through the structured teaching of concepts and language to prepare the child for the first grade? Or should the first concern be with the emotional deficits of the disadvantaged child and with efforts to deepen object relations and foster emotional growth? Is he primarily in need of extra training and stimulation because his intellectual functioning is immature for his age level or is there a deficit in his general ego functioning? What is cognitive learning and concept formation? Is it the acquisition of more and more concepts and information or is it the capacity for the organization of thought that enables the application and formation of concepts in new situations and problems? Without having made good basic relations with people, do children have the basis for the constancy of awareness that is necessary for cognition? Can we try to help children achieve meaningful learning without trying to help them develop some emotional strength?

These are some of the questions that arose in my mind as I observed various and contrasting approaches and programs for preschool teaching.

In all these programs, however, one characteristic stands out: *teaching* has come back to the nursery school. Regardless of the type of program, a great awareness exists of the teacher's role in stimulating cognitive learning and the use of language, in helping the child distinguish between and deepen sensory perceptions. In some programs, the teacher's goal is to stimulate exploration and self-discovery and ultimately the "seeing of relationships" and logical thinking.

## Problems of balance

Until recently, nursery school practice, although originally designed to stimulate exploratory behavior, discovery, and inductive reasoning while promoting the mental health and individuality of each child, has been widely misunderstood as requiring solely a laissez-faire attitude toward children while providing them with loving care in a warm, accepting atmosphere.

But now many persons in the field of early childhood education are redefining their goals and policies and changing their methods. The vague, diffuse perceptions and confused ideas disadvantaged children manifest have pointed up the need for repeated efforts to help them become aware of the different elements of an experience. Many nursery school teachers practice repeated recall of experiences, structured games designed to stimulate heightened perception, and much attention to language enrichment.

In two basic areas of nursery school teaching the problem seems to be one of balance. How much emphasis should be placed on cognitive learning? How much on affective relating and expression of emotional needs? And what is the best timing for each? In the area of teaching techniques how much effort should the teacher spend on direct

teaching in structured situations with clearly defined goals and how much in the creation of opportunities for stimulating discovery, exploratory learning and play, and inductive reasoning?

Perhaps the answer to these questions depends on a clear definition of the cause of cultural deprivation. In Israel, economic deprivation, fatherless homes, and gross social discrimination are not frequent and yet many children show signs of severe cultural deprivation. We must, therefore, look for the cause of cultural deprivation in cultural modes—in interpersonal relationships, in unfulfilled dependency needs, in the lack of a sense of individual worth, and in the conceptions parents have of the parental role, particularly when they do not regard the protection, encouragement, stimulation, and education of their children as necessary aspects of this role. If the causes of cultural deprivation lie in the quality of interpersonal relations, then culturally deprived children need help to develop a new way of relating to people as a "corrective" experience.

The quality of learning and the ease with which children learn have long been known to be directly related to the quality of the teacher-child relationship. This relationship is even more important when the child is culturally deprived, and to have any significant meaning, it should be developed on a one-to-one basis. Of course, along with efforts to overcome such a child's emotional deficits must go efforts to try to enlarge his environment and provide him with intellectual stimulation, broader language experience, and the opportunity to acquire basic skills. But it would seem that before a child can absorb cognitive experiences and utilize them in the organization of the ego, his basic emotional needs have to be met.

## Training and discovery

It has also long been known that an active pursuit of learning is far more effective than passive reception of instruction. The child who climbs a tree because he wants to get to the top gets far better exercise than the child who takes routine gymnastics. Nevertheless, children—especially disadvantaged children—do need structured exercises to help them recall the experiences and ideas they are exposed to in their exploration.

An interesting study of the effects of intellective training of 2- and 3-year-old children, being conducted by Francis Palmer of the City University of New York, includes inquiry into the effects of discovery in comparison with directed training. Dr. Palmer is training two groups of children to acquire new concepts in individual sessions with a teacher; one group by formal training, with the teacher taking the initiative; the other group by presenting the child with materials and allowing him to discover the concepts for himself, the teacher-playmate speaking only in answer to the child's questions. Thus far, Dr. Palmer reports, the results show little difference between these two experimental groups but appreciably greater progress in both than in a control group of children not given an opportunity for an intensive one-to-one interaction with an adult.

Another issue among the designers of preschool education is the question of how much attention should be given to free imaginative play in proportion to structured cognitive learning and information gathering. The Montessori schools have demonstrated that very young children are capable of great feats of learning in reading, arithmetic, geography, and science. But one might question what meaning large, isolated pieces of information have for a young child who has yet to orient himself to his immediate world, has yet to distinguish between fantasy and reality and between magic and natural causes? The child must investigate his environment and organize it through repeated play experiences before he will be ready to absorb and organize information beyond his immediate world.

Opportunities for creative make-believe enable a child to learn how to distinguish between fantasy and reality. A program that denies a child ample opportunity to engage naturally in imaginative dramatic play and stresses only the acquisition of cognitive knowledge and skill may prevent him from pursuing the task of reaching an understanding of his immediate world. It may be filling his mind with elaborate bits of information he is not ready to incorporate into an organized concept of the world and at the same time be stifling his own natural curiosity.

A child learns best when the information and material offered him are in line with the subjects in which he has shown a natural interest, involvement, and curiosity. Certainly his world needs to be widened, but the cue to what material to offer him lies in the interest he reveals in play and work, rather than in any prearranged program of instruction.

## Small groups

As I observed various ways of organizing groups of children, it became clear to me that a teacher can only deepen and strengthen a relationship with a child in a very small group, and that it is better for one teacher to handle a few children alone than for several teachers to handle a large group together. This principle has been applied at the Neighborhood Children's Center in New York City by dividing a group of fifteen 3-year-old children into three "families" with separate teachers and equipment, and a group of twenty-two 4-year-old children into three "families," also with separate teachers and equipment. How the principle can be related to the Israeli situation of very large groups and small budgets remains to be seen.

The problems of the culturally deprived child have also created the need to underline other goals for preschool education such as the development in children of a sense of structure and constancy, a capacity for delaying gratification, greater confidence and self-esteem, and new motives, attitudes, and goals. The child also needs training in "relationship thinking" and logical thinking as well as experiences that will help him learn to understand relationship sequences. Structured exercises in logical thinking for use in sessions with individual children have been developed by Marion Blank at the Albert Einstein College of Medicine, Yeshiva University, New York.

Many people in the United States are thinking hard about all aspects of teaching young deprived children. Martin Deutsch at the Institute for Developmental Studies in New York and Carl Bereiter, who until recently was at the University of Illinois, have refined differing methods for promoting cognitive learning, the teaching of reading, speech, and language structure, and the classification and mastery of specific ideas. Susan Gray at George Peabody College for Teachers in Nashville is concerned not only with cognitive development but also with achieve-

ment goals, capacity for delaying gratification, and the reinforcement of desirable behavior.

The Bank Street College of Education in New York City, which operates the Early Childhood Center, is concerned with both the affective and cognitive aspects of learning in early childhood and sees these as interdependent. The theory is that learning takes place best when it is self-motivated and comes from independent pursuit, active involvement, and direct experience. An emphasis on individuality is basic to the Bank Street program. Incorporated into the program are structured exercises in concepts and language based on the child's own play and activity. The effort is to strike a balance between the exploratory and inductive method and the structured teaching method. The nature of balance varies with each child and is determined by the characteristics of the children and the subject matter.

## Headstart's innovations

I found Project Headstart amazing in the high standards it has set for the centers it supports. For example, it expects the centers to have one teacher, one assistant, and one aide for every 15 children. This would be sheer luxury in Israel. In addition, the centers are expected to employ psychologists, social workers, parent coordinators, and family workers.

There is, however, a problem in staffing because the number of trained persons in the field of early childhood education is inadequate to meet the increased need for trained workers created by the Headstart program.

The vital role assigned to parents in the Headstart program is an important innovation. A staff member whose job is to work with parents is mandatory in each center. Parents make up half of each center's advisory committee.

Thus parents are brought closer to the center in a way natural to the goals, methods, and attitudes of the teachers. From there, it is an easy step to individual work with parents in direct teacher-parent or social worker-parent relationships and to workshops for parents conducted by teachers and social workers. Perhaps, even more important for the disadvantaged parent is the feeling of added stature that comes from his involvement in the center. His attitude toward himself and his children changes because of the opportunity to have a voice in making decisions and being accepted as an equal by the staff. Perhaps this feeling will affect his attitude toward life and relieve some of his feeling of defeat.

Another of Headstart's innovations is the use of neighborhood workers from the community to aid the teachers in the centers. Though at first many professional people were appalled at the thought of untrained people working in semiprofessional positions with young children, in actual practice the idea seems to have worked well in many instances.

How can this apparent success be accounted for? Perhaps it is due to some extraordinary training methods; perhaps, to the heightened self-esteem of the neighborhood workers and their devotion to and belief in the education of children. One benefit may be that the attitudes toward children the project wants to impart will be relayed to the community.

## Very young children

Some efforts are being made to attack the learning problems of disadvantaged children by stimulating intellectual development in infants and very young children. In some places, the work is with infants only; in others, with mothers, too. In the latter experiments, mothers are trained to work with and stimulate their own children.

One of the best known projects of this type is the one established by Bettye M. Caldwell at the Children's Center, State University of New York at Syracuse with funds from the Children's Bureau. This research project cares for infants from the age of 6 months through 4 years in all-day programs designed to promote healthy overall development as well as to raise the IQ or prevent its deterioration. It not only gives the infants good physical care and emotional warmth but also provides many ingenious methods for stimulating intellectual and motor development.

The long-range findings of this program are not yet in, but the project has succeeded in arresting the downward trend in intelligence found in many deprived children after the second year of life and in many cases has raised the level. Nevertheless, it seems to me, the necessary grouping of the children and the need for several workers with each group must lead to a basic lack of the stable one-to-one affective relationship that a child needs for his healthy emotional and intellectual development.

Another project concerned with teaching mothers how to stimulate their children is being conducted by Ira Gordon of the Institute for Development of Human Resources, University of Florida, also with support from the Children's Bureau. As part of its efforts, this project has produced an illustrated booklet for mothers on ways to play with infants. Susan Gray at George Peabody College is conducting a similar project. She is also experimenting with training mothers through demonstrations in the home. She has found that the greatest gains seem to be in the younger children in the families involved.

I question, however, whether short training courses with mothers will be able to change basic cultural patterns of parent-child relationships in parents who themselves suffer from deficits in affective development. It is difficult to see how learning isolated methods will change basic attitudes. Nevertheless, people working with parents maintain they have effected constructive change. Perhaps this method achieves results by reinforcing parents' positive attitudes toward and ambitions for their children. It seems to me, however, that before significant change can be achieved, it may be necessary to help the mother meet her own needs.

## Meaning for Israel

A survey such as this leads one to lean more and more toward an eclectic method.

I found myself more nearly identified with the method of the Bank Street College of Education than with any other method, for it seems to be based on insight into and understanding of child development and to be the most nearly balanced regarding the affective and cognitive aspects of education. But I should like also to use many of the methods for stimulating cognitive learning and perceptive development introduced by Martin Deutsch at the Institute for Developmental Studies. I have also acquired a deeper respect for the young child's

capacity for learning and self-discipline from the demonstrations I saw at the Montessori schools.

Susan Gray's methods of consciously reinforcing desirable behavior and of working toward achievement motivation and toward greater capacity for delaying gratification help spell out goals and methods to which we may frequently have paid only lip service. The Headstart program's efforts to get parents involved, as well as its use and training of neighborhood workers for both preschool and parent work, might be emulated in Israel. The methods of careful scrutiny of each child demonstrated in the psychoanalytically oriented day nurseries should be incorporated into inservice staff development and in teacher training. Much of the content in the Neighborhood Children's Center, where emphasis in the 3-year-old group is on baby care, should be seriously considered.

Many of the methods used in stimulating intellectual development may be useful in infant homes in the kibbutzim, and some may be useful in the everyday home care of young children. There does seem to be a danger, however, of overstimulating the child, of not leaving enough time and energy for self-discovery and exploration.

My acquaintance with the major trends in thinking in the United States about work with disadvantaged preschool children will be valuable in planning our work for disadvantaged children in Israel. It will undoubtedly affect our investigations at the Hebrew University and will ultimately enhance the value of our contribution through experimentation, observations, and research to the world's knowledge of personality development in children.

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# guides and reports

EFFECTIVE SERVICES FOR UNMARRIED PARENTS AND THEIR CHILDREN: innovative community approaches. National Council of Illegitimacy, 44 East 23d Street, New York, N.Y. 10010. 1968. 111 pp. $3.25.

Presents 10 papers given at the 1967 forum of the National Conference on Social Welfare on programs of services to unmarried mothers and fathers in this country and elsewhere.

SALARIES AND MANPOWER IN CHILD WELFARE, 1966. Ralph W. Colvin, Lydia Hylton, and Barbara G. Rothschild. Research Center, Child Welfare League of America, 44 East 23d Street, New York, N.Y. 10010. 1967. 153 pp. $3.

Presents data from a study of professional and subprofessional manpower and salaries, as of January 1, 1966, in 193 voluntary and 15 local public child welfare agencies with membership or provisional membership in the Child Welfare League. Includes comparative data from similar studies for 1958, 1960, and 1963.

MINNESOTA SYMPOSIA ON CHILD PSYCHOLOGY: volume I. Edited by John P. Hill. University of Minnesota Press, Minneapolis, Minn. 55414. 1968. 239 pp. $5.

Presents six papers reporting on research on the socialization of the child living in poverty, theories of behavior in research and clinical practice, parental and environmental influences on cognitive development, and the use of computers in teaching and research.

SOCIAL WORK WITH PREADOLESCENTS AND THEIR FAMILIES: a report on the United Neighborhood Houses Preteen Delinquency Prevention Project, 1962–65. Goodwin P. Garfield and Saul Goldzweig. United Neighborhood Houses, 114 East 22d Street, New York, N.Y. 10016. 1968. 96 pp. $1.50.

Reports the processes used by professional social workers in a 3-year project to provide intensive service to more than 400 disadvantaged 8- to 13-year-old children and their parents to help them deal more effectively with their problems at home, in school, and in the community.

THE PUBLIC LOOKS AT CRIME AND CORRECTIONS. Joint Commission on Correctional Manpower and Training, 1522 K Street, NW., Washington, D.C. 20005. 1968. 28 pp. Single copies available on request from the Commission.

Reports the findings of a survey of 1,000 adults and 200 young people to learn their general attitudes toward correctional work, their feelings about contacts with convicted offenders after release, and their opinions of correctional work as a career.

ROUND TABLE READER, 1967. Malvin Morton, editor. American Public Welfare Association, 1313 East 60th Street, Chicago, Ill. 60637. 1968. 280 pp. $3.

Contains condensations of 23 papers and of discussions presented at the APWA's biennial round-table conference in 1967 concerned with poverty and means of alleviating it.

UNDERSTANDING CHILDREN OF POVERTY. David Gottlieb and Charles E. Ramsey. Science Research Associates, 259 East Erie Street, Chicago, Ill. 60611. 1968. 76 pp. $3.

Presents a sociological analysis of cultural deprivation in children as it is related to family and social life, employment, school performance, and classroom experiences and suggests an approach to education of deprived children.

CHILD VICTIMS OF INCEST. Yvonne M. Tormes. Children's Division, The American Humane Association, P.O. Box 1266, Denver, Colo. 80201. 1968. 40 pp. 50 cents.

Reports the findings of a study of the characteristics of families in which girls 16 years old or younger were victims of sexual assault by their fathers, and suggests guidelines for diagnosis and treatment of family conditions conducive to incest.

an essay review . . .

# NEW PERSPECTIVES ON YOUTH

CATHERINE V. RICHARDS *Special Consultant on Youth Services, Children's Bureau*

At this interval when "the young see themselves—negatively glorified in the mass media"; at this time when youth must bear a disproportionate share of the burdens of social unrest and pervasive and rapid change, two new books provide perspective on youth from clinical observations and theoretical orientations of psychology, psychiatry, and anthropology.

In light of acute historical change, Erik H. Erikson could not escape the necessity of reviewing and reevaluating his concept of identity. Although the last entry in his new work, "Identity, Youth and Crisis," antedates the "explosive momentum of street violence," this thoughtful book on human development engages the reader in thinking with him about identity formation as a necessary step in individual and collective development.*

Erikson's conceptualization of the eight stages of man, described in 1950 in "Childhood and Society,"[1] offered the theory of developmental "crises." Initially this term "crisis" was interpreted as connoting impending catastrophe. As Erikson points out in his new book—a compilation of his more recent writings on identity—the term crisis "is now being accepted as designating a necessary turning point, a crucial moment, in life when development must move one way or another, marshaling resources of growth, recovery, and further differentiation."

Although a crisis is not exclusive to any age or stage of development, this book is concerned only with one developmental crisis, the "identity crisis." Dealing with this crisis is the special task of adolescence and involves the process of developing a sense of personal sameness and historical continuity. It is a complicated psychosocial process located, says Erikson, "in the core of the individual and yet also in the core of his communal culture, a process which establishes in fact, the identity of these two identities."

While theory seems to be of little interest to citizens caught up in unrest and disorder, the irony is that instant problem solving in human development is an inviting but defeating delusion. With respect to the identity crisis of adolescents, Erikson notes: ". . . certainly more 'roles' played interchangeably, more self-conscious 'appearances,' or more strenuous 'postures' cannot possibly be the real thing, although they may be dominant aspects of what today is called the 'search for identity'."

He makes it clear that for many adolescents identity formation is an unconscious process. It is something that is both mental and moral and comes upon the young person when he can say: "This is the real me." This ego strength, says Erikson, "emerges from the mutual confirmation of individual and community, in the sense that society recognizes the young individual as a bearer of fresh energy and that the individual so confirmed recognizes society as a living process which inspires loyalty as it receives it, maintains allegiance as it attracts it, honors confidence as it demands it."

## Oppressed minorities

But there are many young people confronting social situations that bring into focus the interaction of personal growth, communal change, and historical social development and make identity development a painful, difficult, conscious process. This aspect of the problem is reported in a book of a series of research-based papers edited by Eugene B. Brody, M.D., "Minority Group Adolescents in the United States." **

The idea that adolescents are a minority was expressed by some young consultants to the Department of Health, Education, and Welfare. In a discussion with adults that included some officials of the Department serving as "resource persons" [see CHILDREN, September–October 1968, page 206], these young people raised questions about what segments of the adolescent population could be considered as oppressed minorities. Although persistent disagreements arose, there was concensus on these points: "Adolescents are a minority. And although they are not all alike, there are several things they have in common. They have not attained the age of majority—21 years; they are treated as a social category on the basis of stereotypes that do not obtain universally; and they are oppressed people!"

*Erickson, Erik H.: Identity: Youth and Crisis. W. W. Norton & Co., New York, N.Y. 1968. 336 pp. $2.95.

**Brody, Eugene B, M.D.: Minority Group Adolescents in the United States. The Williams and Wilkins Co., Baltimore, Md. 1968. 243 pp. $8.25.

Dr. Brody's book deals with the "crises encountered by people, no longer children, and not yet adults, who belong to important minority groups in the United States: Negro, Mexican, Puerto Rican, Oriental, and American Indian." These young people must surmount not only the universal hurdles between one age-defined status and another, but also hurdles between the cultures of their families of origin in an ethnically determined minority world and the culture of the "surrounding, dominant United States society."

### On alienation

Both Erikson and Brody bring the clarity of rationality to a subject loaded with emotional overtones, "the alienation of youth." Brody sees an upwardly mobile youth in the sense of "marginal man" who has one foot in the majority world and one in his own, but does not feel completely accepted by or comfortable in either. Pointing out that he is using the term "marginal man" in the sense used by Kurt Lewin, he says, ". . . the marginal man by virtue of his transitory condition and ambiguous status suffers from the uncertainty of belongingness."

Erikson's interpretation seems to me to catch and explain the desperate pleas of the young and the minorities to be as he says, "heard and seen, recognized and faced as individuals with a choice rather than as men marked by what is all too superficially visible, namely, their color." And to this may be added, the superficially visible physical or cultural characteristics of age, accent, or attire. Erikson refers to Van Woodward's term of "surrendered identity," to describe the active and powerful demand of the black spokesmen to recover for themselves, and to reconquer for their people, a collective identity that makes for human vitality—a collective identity that can provide a continuity with an historical past, with current community change, and with the development of the individuals in transition from childhood to adult status.

At this time in most communities minority youth have more access to confirmations of negative identity and identity confusion than they do to confirmations of positive identity. As Erikson concludes: "The dominant issue of this as of any other stage, therefore, is the assurance that the active, the selective, ego is in charge and enabled to be in charge by a social structure which grants a given age group the place it needs—and in which it is needed."

But, as F. Musgrove has stated in his well constructed analysis of "Youth and the Social Order,"[2] young people are "trained for adulthood by exclusion from the world of adult concerns, and for the exercise of responsibility by the denial of responsibility." This critical observation takes account of one of the facts of a complicated economy. Young people are needed to prepare for and secure the future, but they are not needed now by the economy. However, this Nation, currently engaged in renewing its efforts to guard the rights of the individual, to insure his development, and to enlarge his opportunity, has need of the personal investment of every citizen in maintaining and developing the society.

Thus, a convergence of events has provided the situation in which both youth and adults are needed in solving the crucial problems of our times. Because there are no rules to go by, but only ethical considerations, youth and adults can work together. Erikson suggests that "a new ethics must eventually transcend the alliance of ideology and technology, for the great question will be how man, on ethical and generational grounds, will limit the use of technological expansion even where it might, for a while, enhance prestige and profit."

Erikson goes on to state, "Moralities sooner or later outlive themselves, ethics never: this is what the need for identity and fidelity, reborn with each generation, seems to point to."

Each of these books provides perspective on youth development in a framework that compels reconsideration of the social structures provided for young people to grow on and in. These books are not blueprints for programs for youth, rather they are the rational expressions of thoughtful, perceptive clinicians who know, as Erikson puts it, that "from generation to generation the test of what you produce is the care it inspires." The unstated question these books raise for every professional person concerned with adolescents is: Do we create a social structure that will accommodate a range of experience for young people with the real adult world and with responsibility that will confirm a positive identity and will "ring true" to the tuning of new and more universal ethics?

[1] Erikson, E. H.: Childhood and society. W. W. Norton & Co., New York. 1950.

[2] Musgrove, F.: Youth and the social order. Indiana University Press, Bloomington, Ind. 1964.

## collected readings

THE WORLD OF THE CHILD: birth to adolescence. Edited by Toby Talbot. Doubleday & Co., 277 Park Avenue, New York, N.Y. 10017. 1968. 457 pp. $1.75.

EDUCATION FOR THE DISADVANTAGED: current issues and research. Harry L. Miller. The Free Press, 866 Third Avenue, New York, N.Y. 10022. 1967. 290 pp. $2.95.

ORGANIZING FOR COMMUNITY WELFARE. Edited by Mayer N. Zald. Quadrangle Books, 180 North Wacker Drive, Chicago, Ill. 60606. 1967. 316 pp. $7.95.

THE CHILD ANALYST AT WORK. Edited by Elisabeth R. Geleerd, M.D. International Universities Press, 239 Park Avenue South, New York, N.Y. 10003. 1967. 310 pp. $7.

CHILDREN: readings in behavior and development. Edited by Ellis D. Evans. Holt, Rinehart & Winston, 383 Madison Avenue, New York, N.Y. 10017. 1968. 571 pp. $5.95.

CONTEMPORARY ISSUES IN DEVELOPMENTAL PSYCHOLOGY. Edited, with commentary, by Norman S. Endler, Lawrence R. Boulter, and Harry Osser. Holt, Rinehart and Winston, 383 Madison Avenue, New York, N.Y. 10017. 1968. 682 pp. $9.95.

BEYOND THE FRONTIER: social process and cultural change. Edited by Paul Bohannan and Fred Plog. The American History Press, Doubleday & Co., 277 Park Avenue, New York, N.Y. 10017. 1967. 213 pp. $6.50, clothbound; $2.50, paperback.

# BOOK NOTES

PSYCHOLOGICAL EVALUATION OF CHILDREN'S HUMAN FIGURE DRAWINGS. Elizabeth Munsterberg Koppitz. Grune & Stratton, New York. 1968. 341 pp. $9.75.

Many years of clinical experience have convinced the author of this study of children's drawings that the test using human figure drawings (HFD's) is one of the most valuable that psychologists can use in evaluating the psychological state of children. She points out that for the most part psychologists consider the HFD tests as either a projective method by which to analyze drawings for signs of unconscious needs, conflicts, and personality traits, or as a measure of mental maturity. Her hypothesis is that HFD's can be used for both purposes.

With this hypothesis in mind, she discusses HFD's from both angles, psychotherapy and children's drawings, brain injury and HFD's, and using HFD's with other psychological tests; and gives clinical interpretations of the drawings that are used to illustrate the book.

THE DISCRIMINATION PROCESS AND DEVELOPMENT. International Series of Monographs in Experimental Psychology, Vol. 5. Brian J. Fellows. Pergamon Press, Long Island City, N.Y. 1968. 218 pp. $10.

According to the author, this book has two purposes: (1) to provide a comprehensive look at the operations involved in the process of visual discrimination; (2) to trace the development of these operations in young children.

To accomplish the first purpose, the author reviews the literature on experimental and theoretical discrimination in animals and human beings and emphasizes the distinction between the perceptual and the cognitive aspects. He shows the operation of the discriminatory process in the form of a cybernetic model. To accomplish the second, he reviews reports of research on discrimination in young children and analyzes the visual discrimination of differently oriented forms as it refers to the performance of a young child.

He concludes the book with a discussion of ways to improve "stimulus processing."

THE CHILD AND THE REPUBLIC: the dawn of modern American child nurture. Bernard Wishy. University of Pennsylvania Press, Philadelphia, Pa. 1968. 205 pp. $6.95.

Preoccupation with child nurture in the United States began at least three generations before Freud and Dewey, according to the author of this look at "child nurture" in this country between 1830 and 1900. In fact, many American ideas of progressive and pragmatic education go back to the Age of Reason, he maintains.

In the 30 years after 1830, American books about child nurture strove to build "character" in the child, the author reports. In the years after 1860, they moved toward fitting the child for life.

Debates over the nature of the child and his destiny raged in all these years, the author maintains, and he discusses many of the arguments advanced. He also takes up the subject of home care and the coming of scientific child study after 1880. He notes that schools throughout the years covered were under attack for offering "frills" rather than sticking to the Three R's.

CONTROLLING DELINQUENTS. Edited by Stanton Wheeler. John Wiley & Sons, New York. 1968. 332 pp. $8.50.

Reports on projects to control juvenile delinquency supported by Federal funds under the Juvenile Delinquency Youth Offenses Control Act of 1961 comprise the content of this book. They are centered on the relationships between young offenders and the persons and agencies who work with them, including the police, juvenile court judges, psychiatric agencies, training schools, caseworkers, and detached workers, and the community's system for dealing with delinquents. The 19 contributors represent the fields of law, medicine, sociology, anthropology, and psychology. The reports are grouped under three headings: the social organization of juvenile delinquency control, agencies and their clients, and community prevention and casework programs. Their unifying theme, according to the editor, is their accent on prevention and control rather than causation.

In his conclusion, the editor maintains that the most important problem suggested by the reports is the necessity to find ways to systematically integrate disparate agencies, their policies, and their operating practices for dealing with delinquents and for taking into account the effect of their actions on the delinquent.

TEMPERAMENT AND BEHAVIOR DISORDERS IN CHILDREN. Alexander Thomas, M.D., Stella Chess, M.D., and Herbert G. Birch, M.D. New York University Press, New York. 1968. 309 pp. $8.50.

On the basis of findings from their 12-year study of young children (the New York Longitudinal Study), the authors in this book consider factors they believe contribute to common behavior disorders in young children (such as temper tantrums, aggressiveness, and abnormal shyness) and a treatment method emphasizing guidance for parents. In addition to discussing case histories, diagnoses, and treatment plans, they draw theoretical and practical conclusions.

The authors recommend that clinicians attend to temperamental as well as environmental and psychodynamic influences in helping a child and his parents. They maintain that mothers who are aware of the influence of temperament and know that pathology in the mother is not the only cause of disturbed behavior in her child will be less likely to develop feelings of guilt and inadequacy. They express a conviction that the difficulties of child raising can be lightened if the average mother can approach the responsibility by recognizing "her child's specific qualities of individuality" and can adopt those practices that are most appropriate to the child's qualities.

# IN THE JOURNALS

## Care of dying children

"In the care of young patients with life-threatening illness, physicians have to treat not only the physical disease, but also the symptoms arising from the anticipation of and the preparation for death," says William M. Easson, M.D., in an article in the July 22, 1968, issue of *JAMA*, the journal of the American Medical Association. ("Care of the Young Patient Who Is Dying.") He points out that the family begins the mourning process when it becomes obvious that the patient is dying and that the loneliness of the dying person may be accentuated because the family and the treatment staff have isolated the patient before he is actually dead.

When a young child is dying, Dr. Easson says, the physician must provide the greatest support not to the child, who is too young to fear death, but to the parents, family, and treatment staff. He discusses the open anger and sense of guilt that some members of the patient's family feel toward the dying child and toward the physician.

Frequently the most difficult problem in the management of the dying patient is with the treatment staff, the author reports, because the dying child arouses "so many difficult feelings" in the people who care for him. The physician must appreciate and learn to manage his own normal reactions to death, he asserts.

## Child abuse

"If we are to spare children from death or permanent injury and have a chance to stabilize the family, intervention . . . at the earliest moment of *suspected* abuse is essential," said the late Cyril H. Winking, then the director of the Illinois Department of Children and Family Services, in a speech to the American Public Welfare Association's 1967 National Round Table Conference published in the July 1968 issue of the quarterly, *Public Welfare*. ("Coping with Child Abuse: One State's Experience.") He reported some results of Illinois' Abused Child Law of 1965, requiring physicians, surgeons, dentists, other practitioners, and hospitals to file reports with the Department of Children and Family Services of suspected abuse of any person under 16 years of age. He pointed out that more than 1,100 cases of child abuse were reported to the department in the 29 months after the law took effect.

Mr. Winking listed four roadblocks to the implementation of abused child legislation—staff shortages, lack of sufficient skill in dealing with the "sick" abuser, scarcity of temporary care and treatment resources, and the widening gap between social agencies and law enforcement agencies.

## Broken appointments

Failure to complete high school, an urban childhood home, and poor marital relations were characteristics of mothers who during a 10-year period had frequently broken medical appointments for their children at a free clinic in Baltimore, Md., according to a study team headed by Oscar C. Stine, M.D., of the University of Maryland Medical School, reporting in the July–August 1968 issue of *Medical Care*. ("Broken Appointments at a Comprehensive Clinic for Children.")

The investigators looked into the relation between the frequency of broken appointments and certain social characteristics of 203 Negro mothers from a low-income area who were registered at a neighborhood maternal and child health clinic of the Johns Hopkins School of Hygiene and Public Health for at least 2 years during the study period. All the families at the time they registered at the clinic had both parents living in the home.

When broken appointments were compared with mother's education, father's social activities, mother's rural or urban origin, her attitude toward her husband, and her reaction toward misbehavior of the children, the team found that a given characteristic had different effects under different circumstances. For example, families with more than average social activity of the father and better education of the mother had the lowest rate of broken appointments, while those with more social activity of the father and less education of the mother had the highest rate.

The team found the completion of high school to be the social characteristic most often associated with keeping medical appointments. In regard to the unexpected finding that mothers of rural origin had better records than those who grew up in urban areas, the team suggests that an urban childhood may promote less organized patterns of behavior than rural.

## Retarded adolescents

The first phase of a project to modify socially unacceptable behavior in mildly retarded adolescents at the Austin (Tex.) State School has increased the rate at which the institutions' residents are being returned to the community, Philip Roos, former superintendent at the school, reports in the August 1968 issue of *Mental Retardation*. ("Initiating Socialization Programs for Socially Inept Adolescents.") The author, who served as first director for the project, points out that 61 young people were discharged from the units involved in the project during its first 2 years in comparison with 35 discharged from the same units in the 2 previous years.

The project was developed to deal with the following causes of unacceptable behavior: (1) cognitive deficits, such as ignorance, lack of sensitivity, failure to benefit from experience; (2) a traumatic interpersonal history including such factors as rejection, failure, low self-esteem retaliatory hostility, and regression to childish behavior; and (3) conflicts between what is acceptable to society and what is acceptable to the subculture of the individual. It uses group and individual counseling, psychotherapy, small group discussions, role playing, field trips, summer camp, prevocational training, and development of avenues for understanding and modifying communities to which the children will return. The project staff served as consultants to the regular ward attendants who remained responsible to the director of cottage life.

# HERE and THERE

## Nutrition

Evidence accumulated in a study of nutritional status of preschool children in Mississippi in the winter of 1967–68 suggests that poor children may regularly receive less than adequate diet, particularly with respect to calories, calcium, and vitamin C. While protein intake was, with few exceptions, found to be generous, the study director points out that in some cases protein is probably serving as an energy source. However, the study found no overt evidence of malnutrition.

The study of 585 Mississippi children selected at random from a 17-county area was undertaken as a pilot study for a nationwide study of the nutritional status of preschool children now being undertaken for the Children's Bureau. It was conducted by George M. Owen, M.D., associate professor of pediatrics at Ohio State University in cooperation with the Mississippi State Board of Health and the University of Mississippi Medical Center. Dr. Owen is also conducting the nationwide study, which got underway this fall.

In the Mississippi study, interviewers visited the homes of the 585 children for 3 successive days to obtain socioeconomic information and learn what food the children had consumed during the 3-day period. About a week after the home visits, medical and laboratory examinations were performed on 504 of the children by physicians who had no knowledge of the social or dietary information obtained on the child being examined. The children included both Caucasians and Negroes and came from both urban and rural areas and from families with per capita incomes of less than $500 to more than $1,500 a year.

The findings showed that in general the greater the per capita income of the child's family the greater his intake of calories, calcium, protein, and vitamin C. Among the 210 children in the lowest income group—under $500 per year per capita—44 percent were classified as low in calorie intake, 38 percent as low in calcium intake, 6 percent as low in protein intake, and 30 percent as low in intake of vitamin C. Among the 135 children in the highest income group—$1,500 or more per capita—16 percent were low in calorie intake, 10 percent in calcium intake, 1 percent in protein intake, and 6 percent in intake of vitamin C.

Analysis of the results of the laboratory examinations showed that, with the exception of thiamine, the children from the lowest income group had a higher proportion of "low" values than the children from the highest income group. This was particularly so for hemoglobin (24 percent of the lowest income group with "low" values as against 6 percent of the highest income group); vitamin C (20 percent and 10 percent); and vitamin $B_2$ (35 percent and 5 percent). Dr. Owen points out that the finding that some children in the highest income group suffered from nutritional deficiencies indicates that nutritional inadequacy is related not only to income but also to dietary habits and food preparation.

No appreciable differences between urban and rural children were found.

## Family planning

On July 16, President Johnson appointed a committee to review Federal policies and programs on population and family planning in relation to worldwide and U.S. needs and to prepare an estimate of the cost of a 5-year program of research, training, and service. The President named 18 persons from inside and outside the Government as members of the committee, with Wilbur J. Cohen, Secretary of the Department of Health, Education, and Welfare as chairman and John D. Rockefeller, III, as cochairman.

The committee report is due in mid-November. Four panels are exploring (1) population change and ways of communicating information, including pertinent information on family planning, to the rising generation, (2) the Federal role in research and training, (3) the responsibility of the Federal Government in seeing that all persons have access to information and services about family planning, and (4) actions the United States might take in concert with other countries to understand and deal effectively with high rates of population growth.

## Smoking and health

"As a matter of public policy, it seems reasonable to ask that cigarettes not be advertised in a way that reaches large numbers of children and young people," the Task Force on Smoking and Health reported to the Surgeon General of the Public Health Service, August 16, after a 10-month study of the hazards of cigarette smoking to health. The Task Force, an 11-member group of representatives of education, medicine, the behavioral sciences, and other fields, was appointed by the Surgeon General in November 1967; Daniel Horn, director of the National Clearinghouse for Smoking and Health of the Public Health Service, served as chairman.

Advertising is one of five "priority" areas in which the 11-member Task Force recommended more vigorous action by the Federal Government, State governments, private agencies, and individuals to influence people's attitudes and behavior with regard to smoking. Other priority areas recommended by the Task Force for preventing or reducing smoking were education of young people, the use by health professionals of their influence on their clientele, the use of group approaches, and the development of less noxious cigarettes and ways of smoking.

To counteract the promotion of a product that can harm its consumers, the Task Force recommended a full-

scale program on smoking and health by the Advertising Council or the Public Health Service working with an advertising agency.

The report also called for an assessment of the influence of advertising on smoking behavior and of the effectiveness of warnings that are broadcast on the hazards of smoking.

In regard to educating young people to refrain from cigarette smoking, the report urged that students have an opportunity to learn about the health consequences of smoking in science, social science, health, and other classes. It recommended that the Department of Health, Education, and Welfare provide financial support to train classroom teachers, develop curricula, and prepare materials on the hazards of smoking; the establishment of a cooperative project using physicians to reach young people with information about the health consequences of smoking; and continuing research on the effectiveness of preventive education.

Among other recommendations were the publication on packages and in advertising of tar and nicotine content of cigarettes, lower insurance rates for nonsmokers, the establishment of a coordinated Federal Council on Smoking and Health, larger budgets for the National Interagency Council on Smoking and Health and the Public Health Service's health education programs.

The Task Force emphasized that the cessation of smoking is, at present, the only protection against cigarette-related disease.

## Youth conference

The tendency for young people today to insist on having a say in the affairs that affect their lives was clearly apparent at a conference of 300 persons convened in Washington, D.C., August 11–14, under the auspices of the National Committee for Children and Youth to discuss ways of making more viable six American institutions: family, church, school, employment, the community, and government. The participants represented, or were selected by, the NCCY, State committees on children and youth, Federal, State, and local public agencies, and national voluntary youth-serving organizations and their local affiliates.

The 200 youth participants included young people from 16 to 22 from various economic and racial backgrounds. Expressing a variety of viewpoints on nearly every subject mentioned, they seemed unanimous only in the opinion that young people need opportunities to influence the decisions that affect them.

"Youth recorders" and "adult participant observers" reported separately on the group discussions at the final plenary session. According to the latter, the discussions indicated that the much publicized "generation gap" is no wider than usual.

Among the recommendations in the young people's reports (admittedly not always representing a group concensus) were the following in regard to—

• *The family:* changes in the welfare system to preserve human dignity; provision of information on family planning and sex education in elementary and secondary schools; liberalization of abortion laws; expansion and improvement of day care centers; examination of the pros and cons of premarital living together as an alternative to early marriage.

• *The church:* comparative religious courses in all schools; the establishment of interfaith councils to work on human problems, especially in the urban ghettos and suburbs, for "people in the suburbs are culturally deprived in their own way."

• *The schools:* elimination of the grading system; courses in minority group history; effective channels of communication between schools and community; a national student lobby.

• *Employment:* government-guaranteed loans or tax incentives to employers to create more job opportunities for hard-core unemployed and underemployed; Federal aid to students; a Federal program to absorb the unemployed; elimination of discrimination in employment; liberalization of child labor laws to eliminate barriers to youth employment.

• *The community:* creation of a national council of youth; the appointment of youth councils as advisors to decision-making bodies and of youth *ombudsmen;* voting power for young people on planning bodies of youth-serving organizations; efforts toward greater integration of the races, with respect for "the right to be different"; dissemination of information on the contribution of minority groups to com-

## A Class For Adoptive Parents

"I didn't realize that there is so much to bathing a baby," a prospective adoptive father attending a session on infant care for adoptive parents told his wife as they practiced with a life-size baby doll as in this picture. The session was one of three in a series sponsored by the Lutheran Family and Children's Services of St. Louis, Mo. Now a regular part of the agency's preplacement adoption service, the series was instituted in 1967 at the request of adoptive mothers who said they felt uncomfortable in classes for natural parents.

The teacher, a registered nurse, gives practical hints to help prepare the couples for baby care. With a 3-month-old girl, she demonstrates how to bathe, diaper, dress, feed, and care for babies. The couples also learn about food, clothing, and equipment needs, normal growth, vaccinations, and health care of young children.

munity life; school-based community forums for social change.

• *Government:* a reduction of the voting age to 18; substitution of a voluntary enlistment or a lottery for the draft; a period of compulsory service to society for *all* young people, including both sexes; revision of the seniority system in Congress to allow younger members greater participation in decision-making; involvement of a large proportion of young people in all aspects of the 1970 White House Conference, including the staff, and provision of financial assistance to defray their expenses.

Some young participants criticized the conference itself for a "reluctance to face controversy" and for its method of selecting youth participants. At the reporting session, a resolution against racism and the war in Vietnam was presented by representatives of an ad hoc committee formed spontaneously the night before by a group of young people, who later collected numerous signatures in its support.

A paper on the implications of the conference for the 1970 White House Conference, prepared by two youth participants, suggested that future conferences include young people who are not associated with any formal club, organization, or institution and recognize the "excellent leadership potential" of youth in urban street gangs.

In the closing conference address, Joseph H. Douglass, director of the 1970 White House Conference on Children and Youth, said that "participation in the world is the most productive task that youth can undertake."

## Mental retardation

The Johns Hopkins Perceptual Test, a test for basic intelligence developed at the Children's Psychiatric Service of Johns Hopkins Hospital in Baltimore, Md., has shown evidence of being useful in large-scale screening of preschool children for mental retardation and in individual testing of children whose intelligence is difficult to measure by other means, according to the findings of a 2-year investigation begun in December 1965 with support from the Children's Bureau. The test was developed under the direction of a psychologist, Leon A. Rosenberg, of the Johns Hopkins University Medical School.

Known as the JHPT, the test involves a child's response to cards placed on a black photograph with a white background, or on a three-dimensional black plastic model that the child can feel as well as look at. Equipment is built into portable cases that are easily set up in hospital rooms, clinics, or schools. The JHPT can be applied to any bedridden child who can be propped up to a 45-degree angle and who can move one hand.

When the JHPT was applied to normal children, the results correlated well with those of other standard intelligence tests, such as the Peabody Picture Vocabulary Test, Columbia Mental Maturity Scale, Leiter International Scale, Stanford-Binet, and Draw-A-Person. It was also found to have a high reliability in retests and to be easily applied by a nonprofessional after a brief training period.

When the JHPT was applied to groups of handicapped children of normal intelligence and nonhandicapped children of normal intelligence of the same age, no significant differences appeared in the results. Among the groups tested were children with severe hearing loss, central nervous system dysfunction, and social-cultural handicaps. In applying the test to children regarded as mentally retarded, a number were identified who had been misdiagnosed because of hearing loss or limited vocabulary and who in further psychological testing showed normal intellectual ability.

Preliminary results of tests in Guatemala and Nigeria indicate that even a change in language does not affect the value of the JHPT as a screening tool for intelligence, according to Dr. Rosenberg.

The JHPT scores of 1,400 children tested in various schools and pediatric clinics in Baltimore, plus demographic data and results of other psychological tests, have been catalogued for future analysis.

The project is continuing studies that will apply the JHPT to children with head injuries, children who have been tutored at age 2, rural preschool children from an area of poverty, and first-grade children in an urban, racially integrated school.

. . .

Citing the harmful effects of improper placement in classes for the mentally retarded on children of "normal" intelligence whose native language is not English, the Southern Arizona Chapter of the National Association of Social Workers has called for serious reexamination of the definitions of mental retardation. In a statement adopted in April 1968, the chapter maintained that frequently children from homes where Spanish or an American Indian language is spoken are classed as mentally retarded because they have scored far below average on verbal portions of psychological tests. It suggested action by State departments of education and local school districts—through bilingual testing, careful retesting, and meaningful supervision—to prevent the misplacement of children in mentally retarded classes because of language barriers.

## Child development

A National Advisory Committee on Dyslexia and Related Reading Disorders, composed of 18 physicians, psychologists, and educators, was appointed by the Secretary of Health, Education, and Welfare, August 23, to examine in detail the disorders that affect the ability to learn how to read, and to make recommendations for a national program to meet the needs of children and adults with reading problems. President Arleigh B. Templeton of Sam Houston State College, Huntsville, Tex., is the committee chairman.

The committee was directed to report on research, diagnosis and evaluation, teacher preparation, and corrective education in the area of dyslexia and related reading disorders.

. . .

More than 750 people from approximately 38 countries attended the 12th World Assembly of the Organisation Mondiale pour l'Education Préscolaire (World Organization for Preschool Education—OMEP) which met in Washington, D.C., July 31–August 7, 1968. OMEP was established 20 years ago to awaken governments, organizations, and parents to the importance of early childhood education to child development. The participants included members of the various professional disciplines interested in children.

In line with the Assembly theme, "The Rights of the Child—The Realization of His Potential," the focus of attention of the major papers, the group discussions, and the interchange among indi-

vidual participants was on the whole child and how to provide the atmosphere at home, in school, and in the community to make it possible for him to be free and creative and to maximize his capacities. While the conference revealed many different cultural patterns for helping children, it also revealed a growing recognition around the world of the importance to child development of the quality of the child's experience in his preschool years.

Some points made at the conference were:

- Research in the whole field of early childhood education needs to be stepped up as a basis for learning what will produce healthier and happier families and healthier and happier nations.
- An appropriate emotional atmosphere and relationships that release children to seek and find learning are far more important than methods of imparting knowledge.
- Because too much pressure on a child to learn early in life can be harmful, governments should adopt laws governing preschool education.
- The development of creative powers demands an emphasis on individuality rather than on likeness.

In summarizing what she feels the goals and values of OMEP are after 6 years as world president. Åse Gruda Skard of Norway said that the organization seeks to ameliorate the educational treatment of small children; create friendship among people of all nations; exchange information; establish laws and change institutions. She said there is a common need for knowledge on how much to direct children; how much to leave them alone; how much to inspire and how much to demand of them.

The new world president, Gaston Mialaret of France, said that his efforts will be to reduce the distance between ideals and achievements in serving young children. Even in good educational environments, he asserted, only the surface of the child's creative power is being touched.

Plans were announced for an impending semi-annual journal to be published by OMEP as a medium for exchanging information and ideas.

# READERS' EXCHANGE

### CLASS: *The real purpose*

The concept of licensing as a preventive child welfare service, propounded by Mr. Class, is long overdue and should be reinforced by all of us. ["Licensing for Child Care," CHILDREN, September–October 1968.]

It is essential for the licenser to enforce legally stipulated minimum standards; this primary function Mr. Class appropriately describes as supervision. However, he wisely puts the emphasis on *consultation* through which a real partnership develops between the licenser and licensee with the common goal of improving agency programs beyond the legal requirements. I wish to underscore in the strongest possible manner Mr. Class's thesis that consultation, although legally secondary, is the most constructive aspect of licensing. This principle of consultation should be established philosophically, legally, and functionally. Although we licensees should understand, accept, and promote this philosophy, the licensers must accept responsibility for legal and administrative action.

Mutual attitudes and understanding will also have to be overhauled if current "scuttlebutt" has any validity. From this source it appears that in too many instances licensees and licensers are not partners working together for the best interests of children, but are mutually suspicious antagonists struggling to maintain their personal or professional point of view. In some parts of the country the relationship between licensers and licensees is apparently characterized by suspicion, distrust, and lack of confidence. In some instances the licensers appear to approach their duties with preconvictions that "something must be wrong and I'm going to find it." On the other hand, we licensees are hardly universally blameless. We sometimes greet the agent with a "freeze out" implying "our house is in order, and if it isn't, it's none of your business."

As Mr. Class says, "only through supervision and consultation can licensing become a dynamic preventive welfare program." I would strongly urge that all licensers adopt Mr. Class's principle and that they send "teachers" rather than investigators on the licensing beat. Most licensees will eventually respond to this kind of approach and support in improving their services.

Although Colorado, my own State, has no provision for consultation as described by Mr. Class, my critical comments do not apply to our agency's experience with the licenser here in Colorado.

**Melvin Philbrick**
*Executive Director, Denver Children's Home, Denver, Colo.*

### *Focus on prevention*

The article by Norris E. Class proved again that Mr. Class is a leader among the thinkers in the field of child care licensing.

As his article points out, licensing child care facilities has traditionally been considered a service to protect children who need care away from home from hazardous facilities and programs. In practice, it has been a regulatory medium through which certain persons, groups, or organizations are authorized to establish and maintain services, because they can meet prescribed requirements, and, conversely, through which operations that do not meet the requirements are disallowed. Protection of any user, child or family, has therefore been the *raison d'etre* of licensing.

I am sure that Mr. Class, in spite of promoting the idea of prevention as the primary objective of licensing, does not negate the value of this kind of protec-

tion of children from the many risks found, even today, in some foster homes, and in many institutions, day care centers, and other group facilities.

What seemed to me important in the article was its highlighting of many components of the licensing function that are too often forgotten. Even more elaboration might be made regarding such needs as: validation of the requirements for issuance of a license; setting goals to achieve standards beyond minimum essentials; constructive use of consultation; public education as to the significance of licensing; continuous updating of requirements; responsible use of the authority vested in the licensing program; and supervision that enables an operator to achieve standards rather than the kind that merely harasses him.

In the long run, however, licensing will not achieve its purposes, nor reach the professional status it properly deserves, nor be appropriately structured, until it is thought of—by the governmental unit responsible for licensing, by the affected licensees, by the users of the facilities, and by the community as a whole—as a positive force for promoting the kind of services that best assure the proper growth and development of the children who need care away from home.

**Roman L. Haremski**
*Deputy Director, Department of Children and Family Services*
*Springfield, Ill.*

### Dampened enthusiasm

Although I was greatly interested in Norris E. Class's article, my enthusiasm for his point of view has been dampened by 20 years of unsuccessful experience in attempting to get an adequate licensing law passed in the State of Ohio.

We have come to recognize that our failure is due in large part to our inability to light a fire with the concept of the prevention of social ills. Sadly, the Ohio State Department of Public Welfare is no more stirred by the possibilities of prevention than is the general public. Perhaps Ohio is particularly lacking in vision. A rich State, it nonetheless provides only inadequate grants for its program of aid to families with dependent children.

I have come to the conclusion that the concept of prevention has little general appeal. It is only when the danger is felt personally that prevention seems worthwhile. Furthermore the measures need to be either simple or relatively undisturbing. Safeguards against polio were easy to get the public to accept. In spite of the fact that more people are killed or maimed by gunshots than were ever crippled by or died of polio even in bad epidemic years, it seems to be very difficult to pass satisfactory gun control measures.

This being the case, how can we arouse enthusiasm for the prevention of social ills by licensing day care services? The social ills are apt to seem only vaguely connected with what happens in unsatisfactory day care. The expense of implementation and the possibility of interfering with somebody's business or private enterprise seem to loom as greater dangers here. How do we convince even the welfare department that there is an urgent task to be done?

Perhaps Ohio is singularly apathetic and lacking in vision. Mr. Class's points are well taken but can he suggest to us what we should do?

**Eleanor M. Hosley**
*Executive Director, The Day Nursery Association of Cleveland*
*Cleveland, Ohio*

### Hard questions

Norris E. Class's analysis of the licensing of child-care facilities as a preventive service should cause welfare administrators and social workers to reappraise this important function.

Mr. Class illuminates the confusion between licensing as a program to prevent misfortune from befalling children generally and child protective service as a program for treating individual children and families.

In addition to the historical factors which have contributed to this confusion, there are also more current factors which may cause resistance to Mr. Class's theoretical position and tend to perpetuate the neglect of licensing as a preventive service. For example, in present day licensing practice, the worker frequently cannot legally act in advance of the arrival of the child, and so only learns of the existence of an unlicensed and marginal facility after children have been taken into care. Also, because of the lack of other "places" for children, the licensing worker often feels compelled to allow the child to remain in a questionable situation and to incorporate into his licensing practice many aspects of a protective service.

Another factor which may cause resistance to Mr. Class's analysis is that persons who supervise licensing and inservice training programs usually have been trained in the casework method so that there is considerable emphasis upon the individual in distress built into their expectation of licensing tasks. Community organization as an appropriate method in child welfare still tends to be neglected in professional education and agency staff development programs; as a result, staff members of a licensing program feel less competent in this method than in the casework method and less interested in its use. Highest status still attaches most often to staff members who are treatment oriented and who deal daily with individual crises and pathology. Thus a licensing staff may find it difficult to look at its program objectively and analytically, and to see it as different from, although complementary to, protective services and placement programs.

If these kinds of factors retard readiness to change licensing practice into a truly preventive service (and there are other factors, such as the reluctance by social workers to use the authority of law), then one wonders what social workers are ready to do as they talk about the importance of "preventive services." Is this only a fashionable label which we wish to attach to our existing treatment and rehabilitation programs? Or will we face hard questions of definitions and theoretical differences in program approaches and goals and make the necessary changes in administrative focus to assure maximum gains for children from each program?

**Lela B. Costin**
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*University of Illinois, Urbana*

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GROUP COUNSELING WITH DELINQUENT YOUTH. Merritt Gilman and Elizabeth Gorlich. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Children's Bureau. CB Publication No. 459. 1968. 38 pp. 30 cents.

Offers guidelines for setting up a group counseling program for delinquents by discussing the composition of groups, the role of the group leader, his training and supervision, the problems he may encounter, recordkeeping, evaluation, and the role and responsibility of the administration.

NARCOTICS: some questions and answers. 6 pp.

LSD: some questions and answers. 7 pp.

MARIHUANA: some questions and answers. 8 pp.

THE UP AND DOWN DRUGS: amphetamines and barbiturates. 7 pp.

Department of Health, Education, and Welfare, Health Services and Mental Health Administration, National Institute of Mental Health. Public Health Service Publications Nos. 1827, 1828, 1829, and 1830, respectively. 1968. 5 cents each. Single copies free from NIMH, Chevy Chase, Md. 20203.

Information on uses and misuses of the specific drugs named in the titles of the folders.

FEDERAL GRANTS FOR TRAINING OF PERSONNEL FOR WORK IN THE FIELD OF CHILD WELFARE. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Children's Bureau. Revised 1968. 19 pp. Single copies free from the Bureau.

Describes the program of grants to institutions of higher learning for teaching, traineeships, and short-term training in the child welfare field administered by the Children's Bureau and the requirements for participation in it.

EDUCATION AND TRAINING FOR CRIMINAL JUSTICE: a directory of programs in universities and agencies (1965–1967). Herman Piven and Abraham Alcabes. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Office of Juvenile Delinquency and Youth Development. JD Publication No. 78. 1968. 126 pp. 70 cents.

Lists over 2,400 academic institutions and service organizations that offer training programs for practice in corrections, law enforcement, and courtwork.

SERVICES FOR CRIPPLED CHILDREN. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Children's Bureau. CB Folder No. 38. 1968. 30 pp. 15 cents.

Describes, in question-and-answer form, the Federal program of grants to the States for services to crippled children administered by the Children's Bureau and lists the official crippled children's agencies in the 50 States and other grant-receiving jurisdictions.

SERVICES FOR CHILDREN AND FAMILIES UNDER THE SOCIAL SECURITY ACT, TITLES IV AND V. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Children's Bureau. 1968. 19 pp. Single copies free from the Bureau.

Outlines the Federal grants program to promote the health and welfare of mothers and children authorized by the Social Security Act as amended through 1967.

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